Gary L. White, DDS

Your Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Gary L. White DDS. By affixing my signature hereto, I hereby authorize, as indicated, Dr. Gary L. White, to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

Printed Name _____ Address _____

_____

Signature _____ Date _____

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile number _____
- ☐ You may contact me at my work telephone number _____
- ☐ You may contact me by e mail at _____
- ☐ You may contact me by text message at _____
- ☐ You may contact me by social media messaging services at _____
- ☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date added/Removed _____
2. _____ Date added/Removed _____
3. _____ Date added/Removed _____
4. _____ Date added/Removed _____
5. _____ Date added/Removed _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communication barriers prohibit obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) _____

Staff Person Initials _____

Patient Consent

Clinical

1. I herby authorize Dr. Gary L. White, here by collectively referred to as "The Practice", to perform all recommended treatment(s).
2. I authorize The Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third party payers and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medications, as needed, and I am fully aware that using certain anesthetic agents involves certain risks, including but not limited to, redness and swelling of tissue, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

By affixing my signature below, I hereby agree and accept the following terms:

1. I am responsible for payment of all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware of a 1.5% MPR or 18% APR will be automatically tabulated into my account balance if my balance becomes 30 days past due. Should my account become delinquent, I will be responsible for any and all collection costs, to include, but not limited to, reasonable attorney's fees and court costs.
2. I understand that a missed appoint fee of $50 will be charged to my account for all missed appointments or last minute cancellations made by me. I am aware that a 24 hour cancellation notice is required.

Insurance

1. I authorize The Practice to submit claims for payment of services rendered or pre-authorizations necessary to my insurance company, on my behalf, and in my name, listed as "signature on file" and assign to The Practice the insurance benefits provided assignment is accepted. I understand that I am responsible for payment regardless of coverage provided.
2. I authorize The Practice to release to staff, hospitals, health care service plans, insurance companies, self insurers or their representatives, any and all information, records and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

I have read and understand the provisions of this Patient Consent and agree to all terms and conditions contained herein.

Patient Signature _____ Date _____

Patient Printed Name _____

Patient Address _____

PATIENT NUMBER

PATIENT NAME _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Physician's Name _____
   Address _____
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications on the back of this form.)
5. Do you routinely take health related substances? ..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
7. Do you have any other allergies? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? .... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
20. Do you have any artificial joints / prosthesis? ..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
22. Have you ever bleed excessively after being cut or injured? ..... YES NO
23. Do you have any stomach problems? ..... YES NO
24. Do you have any kidney problems? ..... YES NO
25. Do you have any liver problems? ..... YES NO
26. Are you diabetic? ..... YES NO
27. Do you have asthma? ..... YES NO
28. Do you have epilepsy or seizure disorders? ..... YES NO
29. Do you or have you had a venereal disease? ..... YES NO
30. Have you tested HIV positive? ..... YES NO
31. Do you have AIDS? ..... YES NO
32. Have you had or do you test positive for hepatitis? ..... YES NO
33. Do you or have you had T.B.? ..... YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco? ..... YES NO
35. Do you consume alcoholic beverages? ..... YES NO
36. Do you habitually use controlled substances? ..... YES NO
37. Have you had psychiatric treatment? ..... YES NO
38. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ... YES NO
39. Do you have any disease, condition, or problem not listed? ..... YES NO
    If so, explain _____
40. Is there anything else we should know about your health that we have not covered in this form? _____
41. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 140MH

MEDICAL HISTORY

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

Patient Registration

Welcome! Please complete the following confidential information to help us serve you better.

Patient: _____
Address: _____
City _____ State _____ Zip Code _____
Telephone: (home) _____ (work) _____ (cell) _____
Employer / School _____
Date of Birth _____ Social Security # _____-_____-_____
Referred by: _____

Do you have Dental Insurance? Yes No Are you the Policy Holder Yes No

Name of Police Holder: _____ Date of Birth _____
Employer _____ Insurance Company _____
ID # _____ Group # _____

Secondary Coverage? Yes No
Name of Police Holder: _____ Date of Birth _____
Employer _____ Insurance Company _____
ID # _____ Group # _____

Account Information:
Send Bill to:
Name _____
Patient: _____
Address: _____
City _____ State _____ Zip Code _____
Telephone: (home) _____ (work) _____ (cell) _____
Employer / School _____
Social Security # _____-_____-_____ Employer _____

In case of Emergency, whom should we contact?

Name _____

Relationship _____ Phone _____