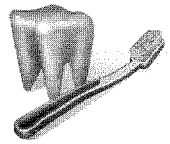
Welcome!!



Gerald A. Clark, DDS, INC.

Patient Information:

Today's Date: _____

SS#: _____

Last Name: _____

First Name & Middle Initial:

_____

Address: _____

City: _____

State: _____ Zip Code: _____ County: _____

Email: _____

Sex: _____ Male _____ Female

Birth date: _____ Age: _____

Circle One: Married Single Minor

Separated Divorced Partnered for _____ years.

Occupation: _____

Employer: _____

Employer Phone#: _____

Spouse's Name: _____

Birth date: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Dental Insurance:

Subscriber's Name: _____

Insurance Co: _____

Group#: _____

Subscriber ID: _____

Is the patient covered by additional insurance? Y N

Subscriber's Name: _____

Insurance Co: _____

Group#: _____

Subscriber ID: _____

Assignment & Release:

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to Dr. Clark all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Dr. Clark may use my health information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payments for service and determining insurance benefits or the benefits payable for related services.

Signature: _____

Phone Numbers

Home: _____ Work: _____ Cell: _____

Best time and place to reach you: _____

EMERGENCY CONTACT (specify someone who does not live in your house hold.)

Name: _____ Relationship:_____

Primary phone: _____ Alt. phone:_____

Dental History

Reason for today's visit:_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Please check if you've had any of the following:

___ Bad breath

___ Blisters on lips or mouth

___ Burning sensation on tongue

___ Chew on one side of mouth

___ Cigarette, pipe, cigar smoking

___ Clicking or popping jaw

____ Dry mouth

____ Fingernail biting

____ Food collection in teeth

____ Foreign objects

____ Grinding/clenching teeth

____ Gums swollen or tender

____ Jaw pain or tiredness

____ Lip or cheek biting

____ Loose teeth/broken fillings

____ Mouth breathing

___ Mouth pain, brushing

___ Orthodontic Treatment

___ Pain around ear

___ Periodontal Treatment

___ Sensitivity to hot/cold

___ Sensitivity to sweets

___ Sores/growth in mouth

Are you interested in having (check all that apply): Whiter Teeth? ___

Straighter Teeth ? ___

A more confident smile? ___

Health History

Physician's Name: _____ Date of last visit: _____

Have you taken any of the drugs collectively referred to as "fen-phen?" these include combinations of Ionimin, Adiplex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) or Redux (dexfentluramine). ____ Yes ____ No

Please check if you've had any of the following:

___ ADD/ADHD

___ Aids/HIV

___ Anemia

___ Arthritis, Rheumatism

___ Artificial Heart Valves

___ Artificial Joints

___ Asthma

___ Back Problems

___ Bleeding abnormally with Extractions or surgery

___ Blood Disease

___ Cancer

___ Chemical Dependency

___ Chemotherapy

___ Circulatory Problems

___ Congenital Heart Lesions

___ Cortisone Treatments

___ Cough, Persistent, Bloody

___ Diabetes

___ Epilepsy

___ Emphysema

___ Fainting or dizziness

___ Glaucoma

___ Headaches

___ Heart Murmur

___ Heart Problems

___ Hepatitis Type ___

___ Herpes

___ High Blood Pressure

___ Jaundice

Health History, Cont.

___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mitral Valve Prolapse
___ Nervousness/Depression
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Sinus Trouble
___ Skin Rash
___ Special Diet
___ Stroke
___ Swollen Feet or Ankles
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumor/growth on head or neck
___ Ulcer
___ Venereal Disease
___ Unexplained Weight Loss
___ Do you wear contact lenses?

Women: ___ Pregnant - Due Date: _____ ___ Nursing ___ Taking Birth Control Pills

Medications

List ALL medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

Allergies

Please check all that apply:

___ Aspirin
___ Barbiturates
___ Iodine
___ Local Anesthetic
___ Penicillin
___ Latex
___ Sulfa
___ Codeine

Other:_____

_____

Gerald A. Clark, DDS, Inc.

Acknowledgement of Receipt of Notice of Privacy Act

You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

Disclosure Acknowledgement

In general, the HIPAA privacy rule gives the patient the right to request a restriction on uses and disclosures of their protected health information (PHI). The patients is also provided the right to request confidential communication or that a communication of PHI be made by alternate means.

I wish to be contacted in the following manner. (Check all that Apply)

____ Home Telephone: _____

- ____ Leave message with detailed information
- ____ Leave message with call back number only
- ____ Give a detailed message to family member

____ Written communications

- ____ Mail to my home address
- ____ Mail to my work/office

____ Work telephone: _____

- ____ Leave message with detailed information
- ____ Leave message with call back number only

____ Fax number _____

____ Email: _____

____ Other:_____

Patient Signature: _____ Print Name:_____ Date: _____

FOR OFFICE USE ONLY

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

____ Individual refused to sign

____ Communications barrier prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please specify):_____

Charleston, WV 25301

Gerald A. Clark, DDS, Inc.

1218 Virginia Street, East, Suite B

Financial Policy

As a team, our mission is to provide the finest and most comprehensive dental care available today. In addition, we are also dedicated to making top-quality care as affordable as possible. In order to do this we request that payment is made at the time of treatment. To help assist you with you dental investment, we provide the following payment options.

1. **Cash**- includes money orders and personal checks.
2. **Visa/Master Card**
3. **Care Credit** – A monthly payment plan we offer to assist you and your family. We offer an Interest Free Option and an Extended Payment Plan Option. (Please see office manager for more details)
4. **Insurance** – As a courtesy to you, we will bill your insurance. You are responsible for all deductibles and "co-pays" that are due on the date of treatment. Your coverage will vary depending on the plan selected by you and your employer. We try out best to estimate your balance due after insurance based on the information we are provided. However, sometimes we may be slightly off, leaving you with a balance. If a claim goes unpaid for 90 days, you will receive a statement from our office asking you to contact the insurance company. Our office participates with many different insurance companies. If we do not participate with your insurance company, you will be asked to pay for all services; but we will be glad to submit a claim for you. Please feel free to speak to the office manager about any questions regarding your insurance or your account.

Appointment Policy

In order for us to continue to provide top quality service to all of our patients, we are asking that you please abide by out policy for missed appointments and late cancellations. Please remember that the appointment scheduled is dedicated time **JUST FOR YOU** to have your dental treatment completed. Please note the following:

1. Failure to keep a scheduled appointment is considered a "missed appointment"
2. Appointments cancelled with less than 24 hour notice will be considered a "missed appointment." The 24 hours does not include Saturdays or Sundays. If your appointment is on a Monday, you **MUST** call on Friday.
3. After two "missed appointments", we will no longer be able to provide you service.
4. We reserve the right to charge for a "missed appointment."

We understand that there are some unusual emergency situations that could arise, but please notify our office immediately.

Our goal is to provide you with quality dental service in a timely fashion, but please remember that emergencies do arise that could possibly affect your appointment time. We sympathize with our patients that are in need, and will do all we can to help them. We ask that you please be patient and understand that you and your family will get the same quality time and service in an emergency situation.

Thank you for your cooperation!

I have read the above polices and I agree to abide by its terms as stated

Patient/Responsible Party: _____ Date:_____