Gabhart Family Dentistry
Creating a Lifetime of Smiles

JAMES W. GABHART II, DMD
JESSICA G. SMITH, DMD

WWW.DRGABHART.COM
TEL: 270-982-3624

FAMILY AND COSMETIC DENTISTRY

Find us on Facebook
Instagram

535 WESTPORT RD.
ELIZABETHTOWN, KY 42701

PATIENT INFORMATION

Date:

Patient:

LAST FIRST MI PREFERRED NAME TITLE

GENDER: CHILD: ☐

IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S): MARITAL STATUS:

Dental Insurance:

COMPANY NAME:

POLICY HOLDER'S NAME: MEMBER ID

POLICY HOLDER'S DOB: #: GROUP #:

POLICY HOLDER'S SOCIAL: PHONE #:

Patient Date of Birth: Patient SSN:

Address: ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP CODE

HOME #:
CELL #:
OTHER #:

E-Mail:

REFERRAL? ◯ YES ◯ NO REFERRED BY:

MEDICAL HISTORY UPDATES

General Health: ◯ GOOD ◯ FAIR ◯ POOR

◯ Y ◯ N Under a physician's care now?
◯ Y ◯ N Any hospitalization in the past 5 years?
◯ Y ◯ N Any serious illnesses/surgeries?
◯ Y ◯ N Use tobacco in any form or vape? If Yes, Type:
◯ Y ◯ N Is pre-medication required before dental visits due to heart condition or artificial joint?

Female Patients: ◯ YES ◯ NO Currently Nursing? ◯ YES ◯ NO Currently Pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ◯ Y ◯ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ◯ Y ◯ N
If yes, please describe:

Do you have dental anxiety? ◯ Y ◯ N

Have you ever been or are you currently in treatment for drug/alcohol abuse? ◯ Y ◯ N

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ALL PATIENTS: Do you have, or have ever had, any of the following? (Check all that apply)

☐ None

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ CEREBRAL PALSEY
- ☐ CHEMICAL DEPENDENCY
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIALYSIS
- ☐ EMPHYSEMA
- ☐ EPILEPSY/SEIZURES
- ☐ GLAUCOMA
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RECREATIONAL DRUG USE
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

OTHER - LIST:

LIST RECENT SURGERIES:

ALLERGIES/ALLERGIC REACTIONS

☐ None

All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply)

- ☐ ASPIRIN
- ☐ ANESTHETIC -LOCAL
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ FOOD
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLEN/OTHER ANTIBIOTICS

OTHER -PLEASE LIST:

MEDICATION INFORMATION

Drug Name: (Include OTC and Recreational Drugs)	Dosage	Reason Prescribed

List any person or organization that you authorize Gabhart Family Dentistry to discuss your dental records and account info with:

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: Date: Relationship to Patient: ◯ Adult Parent ◯ Guardian ◯ Parent ◯ Other

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ACKNOWLEDGEMENT OF PRACTICE POLICIES

Updated 2015

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices.

I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I authorize Dr. Gabhart to administer consultation and treatment for dental related conditions I possess. As with any medical/dental procedure treatment I understand that there are unknown risks. I understand that any matters and any questions I pose with be discussed with Dr. Gabhart during consultation before I accept treatment.

I hereby assign to Dr. James W. Gabhart II D.M.D all insurance benefits and payments to which I am entitled from whatever source for any services, materials' and supplies which are furnished to me in conjunction with my dental treatment. I authorize Dr. Gabhart and his staff to seek such benefits and payments on my behalf. It is understood that Dr. Gabhart's office will bill my insurance company for any dental treatment and that my assignment of benefits is ongoing and continuous unless and until cancelled by me in writing to my insurance company and to Dr. Gabhart's office.

I understand that my insurance benefits are a contract between my insurance company and me. Thus, I understand that Dr. Gabhart's office will assist me in filing claims for dental treatment rendered; however I agree that I am ultimately responsible for ensuring that payment in full is made to Dr. Gabhart for all consultation and treatment that I have in this office. For whatever reason and to whatever extent Dr. Gabhart does not receive payment from my insurance carrier, I do hereby agree to pay the balance in full within 30 days of receipt of notification.

I understand that all fees are due and payable at the time that services are rendered. Any invoices remaining outstanding and unpaid beyond sixty (60) days could result in outside collection activity. I agree that if this account is not paid when due, and this office should retain an attorney or collection agency for collection. I agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

I _____, have had full opportunity to read and consider the contents of this form including consent for care, HIPAA, Notice of Privacy Practices, terms and conditions of insurance benefits, financial responsibility and our financial policy, and therefore I am giving consent for treatment and I agree to the conditions and above terms.

Signature of patient, parent or guardian _____ **Date** _____