BLACKROCK DENTAL, PLLC

Joshua R. Gibbons, DDS & Joshua J. Miles, DDS

Welcome to our practice

Thank you for giving us the opportunity to serve your dental needs

Patient Information

Date _____ Home Phone (___) _____ Cell Phone (___) _____

May Blackrock Dental remind you of your appointment via text message and email? ☐ Yes ☐ No

Name _____ Preferred Name _____
First Middle Initial Last

Address _____ Social Security # _____

City _____ E-Mail _____

State _____ Zip _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex ☐ Male ☐ Female Age _____ Birthdate _____ ☐ Separated ☐ Divorced

Patient Employer _____ Spouse Name _____

Patient Employer Phone # _____ Spouse Employer _____

Spouse Employer Phone #_____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone (___) _____

Responsible Party & Primary Insurance

Name of Person Responsible for Account _____
First Middle Initial Last

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Phone Number (___) _____

City _____ State _____ Zip _____ Cell Number (___)_____

Person Responsible Employed by _____ Business Phone # _____

Policy Holder _____ Employer Name _____
First Middle Initial Last

Insurance Company _____

Social Security # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient) _____ Phone Number (___) _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Business Phone # _____

Insurance Company _____

Social Security # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Medical History

Physician's Name _____ Date of Last Visit _____

Are you under a physician's care now? ☐ yes ☐ no _____

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no _____

Have you ever had a serious head or neck injury? ☐ yes ☐ no _____

Are you taking "Fosamax" or any Osteoporosis Medication? ☐ yes ☐ no if yes circle IV or ORAL

Are you taking any medications, pills or drugs? ☐ yes ☐ no if yes, please list medication and dosage

_____

_____

Do you use tobacco? ☐ yes ☐ no Are you Pregnant or trying to get pregnant ☐ yes ☐ no

Do you use controlled substances? ☐ yes ☐ no Are you nursing? ☐ yes ☐ no

Do you vape? ☐ yes ☐ no

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other – please explain _____

Do you have, or have you had any of the following?

□ AIDS/HIV Positive	□ Congenital Heart Disorder	□ Hepatitis A	□ Recent Weight Loss
□ Alzheimer's Disease	□ Convulsions	□ Hepatitis B or C	□ Renal Dialysis
□ Anaphylaxis	□ Diabetes	□ Herpes	□ Rheumatic Fever
□ Anemia	□ Drug Addiction	□ High Blood Pressure	□ Rheumatism
□ Angina	□ Emphysema	□ Hives or Rash	□ Sickle Cell Disease
□ Arthritis/Gout	□ Epilepsy or Seizures	□ Hypoglycemia	□ Sinus Trouble
□ Artificial Heart Valve	□ Excessive Bleeding	□ Irregular Heartbeat	□ Stomach/Intestinal Disease
□ Artificial Joint	□ Excessive Thirst	□ Kidney Problems	□ Stroke
□ Asthma	□ Fainting Spells/Dizziness	□ Leukemia	□ Swelling of Limbs
□ Blood Disease	□ Frequent Cough	□ Liver Disease	□ Thyroid Disease
□ Blood Transfusion	□ Frequent Headaches	□ Low Blood Pressure	□ Tumors or Growths
□ Breathing Problem	□ HPV-Human Papilloma Virus	□ Lung Disease	□ Tuberculosis
□ Bruise Easily	□ Heart Attack/Failure	□ Mitral Valve Prolapse	□ Ulcers
□ Cancer	□ Heart Murmur	□ Pain in Jaw Joints	□ Anxiety
□ Chemotherapy	□ Heart Pace Maker	□ Parathyroid Disease	□ Osteoporosis
□ Chest Pains	□ Heart Trouble/Disease	□ Psychiatric Care	
□ Cold Sores/Fever Blister	□ Hemophilia	□ Radiation Treatments	

Have you ever had any serious illness not listed above □ Yes □ No If Yes to this or any of the above, please explain

_____

_____

Dental History

Reason for today's visit? _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Have you had problems with any of the following?

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to hot
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or Popping Jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food catches between teeth	□ Sensitivity to cold	□ Sores or growths in or near mouth

Are you happy with the appearance of your teeth? _____

Have you ever had a bad experience in a dental office? ☐ yes ☐ no _____

Authorization and Release

I understand and acknowledge that all questions have been accurately answered and that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered, to me or my child during the period of such dental care to third party payors and/or healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I acknowledge that payment is due at the time of treatment unless other arrangements have been made. I understand that I will be assessed an 18% annual finance charge on any balance over 60 days.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Date

Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

Signature _____ Date _____

Financial Agreement

We, the undersigned, individually or as agent for the patient, understand and agree, jointly and severally, to the following.

If this account is sent to collections, we agree that in addition to any amount left owing to Blackrock Dental, PLLC, we will be responsible for interest at a rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

We specifically authorize Blackrock Dental, PLLC or any assignee thereof, to access our credit file should this account become delinquent. We recognize that insurance is a contract between the patient and insurance company, and agree to pay all charges under this agreement regardless of any insurance coverage. This agreement shall apply to any unpaid services owed to Blackrock Dental, PLLC in writing that is to be revoked. We have either received or refused a copy of this agreement. We agree that no oral agreements have been made and that this agreement cannot be modified orally.

We acknowledge that Blackrock Dental, PLLC, including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, including a cell phone, by means of an automatic telephone dialing system or an artificial or prerecorded voice, or by a live caller, and that we will bear the cost of any charges associated with such a call.

We have read this agreement and understand its terms. A copy or fax of this document shall have the same legal effect as the original.

_____ _____ _____

Signature of Patient/Authorized Representative Date Your Relationship to Patient