Glenstone Dental

Dr. Holly Clark and Dr. Philip Gastinel

Patient Information

Patient Name: _____ Date_____
Last First MI

Address _____
Street Apartment #

_____
City State Zip Code

Sex: ☐ Male ☐ Female Check appropriate box: ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date_____ Social Security # _____ Drivers License #_____

Home Phone _____ Work Phone _____Cell Phone_____

Employer:_____ Email address:_____

How did you hear about us?
Website__ Insurance __ Referred by:_____

Person to contact in case of emergency_____Phone_____

Health Information

Have you been under a physician's care during the past 2 years?_____For?_____

Name of physician_____Phone_____

List all major surgeries with approximate dates:_____

List all medications you are presently taking (or attach list)_____

_____

Are you currently taking any of the following? __ Anticoagulants (Blood Thinners) __ Aspirin or drugs such as Motrin, Aleve, Ibuprophen? Yes___ No____

Do you smoke or use tobacco in any form?_____ If so, what type and how often?_____

Please check any of the following that you are allergic to or have had a bad reaction to:

❑Local Anesthetics ❑Codeine ❑Sulfa Drugs ❑Iodine ❑Aspirin ❑Penicillin ❑Latex ❑Barbituates

Other_____

Please place a mark to indicate if you have or have had any of the following:

❑	Allergies	❑	Emphysema / COPD	❑	Mitral Valve Prolapse
❑	Alzheimer's or Dementia	❑	Epilepsy	❑	Nervous Disorder
❑	Anemia	❑	Excessive Bleeding	❑	Organ Transplant
❑	Arthritis or Lupus	❑	Fainting	❑	Osteoporosis
❑	Artificial Joints (Hip, Knee)	❑	Glaucoma	❑	Pacemaker
❑	Asthma	❑	Head Injury	❑	Parkinson's Disease
❑	Atrial Fibrillation	❑	Heart Disease	❑	Pregnant or Nursing "Currently"
❑	Artificial Heart Valve	❑	Heart Attack/Failure	❑	Radiation Treatment
❑	Auto-immune Disease	❑	Heart Murmur	❑	Respiratory Problems
❑	Blood Disease	❑	Hepatitis - Type_____	❑	Rheumatic Fever
❑	Blood Transfusion	❑	High Blood Pressure	❑	Sickle Cell Anemia
❑	Cancer	❑	HIV	❑	Sleep Apnea
❑	Chemotherapy	❑	Jaw Surgery	❑	Stroke
❑	Diabetes	❑	Kidney Disease	❑	Tuberculosis
❑	Dizzy Spells	❑	Liver Disease	❑	Ulcers
❑	Drug Dependency	❑	Mental Disorder	❑	

Any other conditions not listed above – please specify: _____

_____

Reason for today's visit_____

Date of last dental visit_____**Date of last dental x-rays**_____

Responsible Party Information

Name of person responsible for this account_____

Billing Address _____
Street Apartment #

_____
City State Zip Code

Home Phone_____ Work Phone_____Relationship to Patient_____

Permission for Dental Treatment for Minors

I hereby give permission for the doctors to render all necessary dental services and to use such methods and agents as they see fit for the child named on this form. I understand that no treatment will be started until the recommend treatment, time involved, and financial investment have been discussed with me.

Parent or Guardian Signature:_____Date_____

Dental Insurance Information

Name of Insured: _____ Insured's Birth Date: _____
Last First

Insured's Soc. Sec. #_____ ID #: _____ Group #_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number:_____

Assignment and Release

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Insurance Authorization Signature._____ Date_____

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made **prior** to the appointment. We may accept assignment of benefits after verification of coverage. However, all deductibles and co-payments are due **at the time of service**. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you, your employer and your insurance company**. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under certain dental policies, therefore you will be responsible for the balance. Initials**_____

Prescription Policy

It is our policy that prescriptions for pain medicine will not be given between Thursday at 3:00 p.m. and 7:30 a.m. Monday.

I have read and understand the office policy.
Signature:_____**Date:**_____

Glenstone Dental

Dr. Holly Clark and Dr. Philip Gastinel
10552 S. Glenstone Place
Baton Rouge, LA 70810
225-767-6400

Appointment Cancellation Policy Agreement

Our office is committed to providing our patients with exceptional care. When a patient cancels without giving enough notice, it prevents another patient from being seen.

Please call our office at least 48 business hours in advance of your scheduled appointment to notify us of any changes or cancellations.

To cancel a Monday appointment, please call our office on Thursday.

If proper notice is not given, our office reserves the right to charge a **$50 missed appointment fee**.

Please note: Reminder messages will be sent via text or phone call as a courtesy only. It is the patient's responsibility to keep scheduled appointments regardless of whether the patient received a reminder.

Please sign below to acknowledge this agreement.

Printed Name _____

Signature _____ Date _____

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Acknowledgement of Receipt of HIPAA Policies and Procedures

You May Refuse to Sign This Acknowledgment

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

Print Name:_____

Signature:_____

Date:_____