GREGORY GUTGSELL & DARREN PHIPPS
Professional Association
P.O. Box 265, New London, NH 03257

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ Date _____

Mailing Address _____

Physical Address _____

Phone Numbers -Home_____ Work _____Cell _____

Date of Birth _____ Sex M__ F__ Marital Status _____

Name of Spouse _____ email address_____

ACCOUNT INFORMATION (IF DIFFERENT FROM ABOVE)

Person Financially Responsible for this Account_____

Relationship to Patient _____ Phone # Home _____Work _____

Mailing Address _____

Physical Address _____

DENTAL INSURANCE INFORMATION

Name of Policy Holder_____Date of Birth _____

Subscriber Identification # _____Social Security #_____

Policy Group Number _____ Relationship to Patient _____

Name of Employer _____ Address _____

Name of Insurance Company _____ Phone # _____

Billing Address _____

SECONDARY DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Name of Policy Holder_____Date of Birth _____

Subscriber Identification # _____Social Security #_____

Policy Group Number _____ Relationship to Patient _____

Name of Employer _____ Address _____

Name of Insurance Company _____ Phone # _____

Billing Address _____

Gutgsell & Phipps, DDS, PA

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Do you need to premedicate for dentistry? Yes No
With what medication? _____

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FINANCIAL POLICY-GUTGSELL & PHIPPS, DDS, PA

Please return this form signed, with medical history. Thank you!

Welcome to our practice! It is the goal of our practice to maintain the highest of standards and provide you with quality dental care. In order to achieve a mutually satisfying relationship, we are providing you with the following information to avoid any misunderstanding or disagreement concerning payment for professional services.

Payment/co-payment is expected at time of service. Whenever possible, we will estimate fees in advance of your visit. Insurance co-payments will be estimated at the time of your appointment. For your convenience, in addition to cash and checks, we also accept Master Card, Visa, Discover, American Express and Care Credit.

Any extensive treatment that needs to be done should be discussed with the Financial Manager prior to the scheduling of appointments. If you should need to make payments over time, please inquire about Care Credit.

If any account is not paid within 25 days from the date of service, finance charges will be added to the account at a rate of 1.5%/month, for an annual percentage rate of 18%. This is applied to the previous month's balance.

In the case of failure to make payment, any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account, will be added to the account.

Fees quoted by the dental office are only valid for 90 days from the date of the quote.

Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered under your plan. We are happy to provide the service of submitting your claim, but all payments are ultimately your responsibility.

You may at any time terminate or postpone treatment, understanding that to do so may compromise your dental health.

A fee of $75.00 will be charged for broken or cancelled appointments. There will be no charge for appointments cancelled with 24 hour notice.
Office hours are 8:00 AM – 5:00 PM, Monday through Friday.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR POLICY, OR NEED ASSISTANCE, PLEASE CONTACT THE FINANCIAL OFFICE. WE ARE HAPPY TO HELP!

Signature:_____ **Date:**_____