PLEASE FILL OUT THESE FORMS **COMPLETELY**. IF YOU HAVE ANY QUESTIONS, PLEASE DON'T HESITATE TO ASK FOR ASSISTANCE.

Date: ________________

PATIENT INFORMATION

Full Name: ______________________________ ______________________
First Last Middle Initial Preferred Name

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ☐ Child/Minor (Name of Guardian: ______________________)

Social Security #: ______________________ Birthdate: ______________________

Reason for this visit: ____

RESPONSIBLE PARTY INFORMATION

Would you prefer text message or phone call reminders? Text ☐ ***Call*** ☐ ***Both*** ☐

Phone (Home): ________________ (Work): ________________ Ext: _____ (Cell): ________________

Address: ____
Street Apartment #

____
City State Zip Code

E-Mail Address: ______________________ Driver's License Number: ________________
(We do not sell or distribute your e-mail address)

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship to Patient: ________________

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home): ________________ (Work): ________________ Ext: _____ (Cell): ________________

PRIMARY DENTAL INS INFORMATION

☐ I do not have dental insurance ☐ This insurance is mine ☐ I have insurance under a spouse/family member

Insured's Name: ______________________

Insurance Company: ______________________

Customer Service Telephone: ______________________

Insurance Group Number: ______________________

Insured's Employer: ______________________

Insured SSN: ________________ DOB: ____________

SECONDARY DENTAL INS INFORMATION

☐ I do not have dental insurance ☐ This insurance is mine ☐ I have insurance under a spouse/family member

Insured's Name: ______________________

Insurance Company: ______________________

Customer Service Telephone: ______________________

Insurance Group Number: ______________________

Insured's Employer: ______________________

Insured SSN: ________________ DOB: ____________

REFERRAL INFORMATION

☑ Please check as many as apply

Television (check all possibilities): ☐ Cox/DrGTV ☐ BlabTV ☐ WEAR (Channel 3) ☐ Mediacom ☐ AT&T/U-verse

☐ Website/Internet Search ☐ Facebook/Twitter ☐ Building/Location ☐ Yellow Pages ☐ Mailed Flyer ☐ Dental Postcard

☐ Have/Saw Magnet ☐ Other ________________ ☐ Another person: ________________
(Let us know who, so we can thank them!)

To the best of my knowledge, all of the information provided is true and correct. If I ever have a change in my health, I will inform the doctor at my next appointment without fail.

→ **Please Turn Over**

DENTAL HISTORY

	YES	NO
Last date of COMPLETE dental exam:		
Date of last FULL MOUTH X-RAYS (16 films or panoramic):		
Are you having any PROBLEMS right now?	☐	☐
If so, what?		
Is your present dental health POOR?	☐	☐
Do you wear a DENTURE (partial or full)?	☐	☐
Are you UNHAPPY with your denture(s)?	☐	☐
Would you like to know more about PERMANENT TOOTH REPLACEMENTS?	☐	☐
Are your AFRAID of dental treatment?	☐	☐
Have you ever had any PERIODONTAL (GUM) treatment(s)?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to **hot**, **cold**, **sweets**, **pressure** ...or **not sensitive**? (circle any that apply)		
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you snore or have sleep apnea?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you use DENTAL FLOSS **daily**, **weekly**, **monthly** or **never**? (circle any)		

Please rank the following in the order which would KEEP YOU FROM completing any needed/wanted dental treatment.
(1 being least worrisome and 4 being most worrisome)

# ___ FEAR of pain	# ___ LACK of concern
# ___ COST of treatment	# ___ MISSING work time

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

- ☐ Bad breath/Unpleasant taste in mouth
- ☐ Strong gag reflex
- ☐ Loose teeth
- ☐ Loose or broken fillings
- ☐ Frequent blisters on lips/mouth
- ☐ Chewing on only one side of mouth

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you currently under a PHYSICIAN'S CARE?	☐	☐
If so, for what?		
List ANY **ALLERGIES**:		
List any MEDICATIONS are you currently taking. ☐ Not currently on medication		
Have you taken ANY medication for OSTEOPOROSIS in the last 12 months?	☐	☐
Are you currently PREGNANT?	☐	☐
Do you use cigarettes/cigars, pipes or chewing tobacco?	☐	☐

PLEASE CHECK YES OR NO TO THE FOLLOWING THAT YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Glaucoma	☐	☐	Nervous system problems	☐	☐
Anaphylaxis	☐	☐	Growths	☐	☐	Osteoporosis	☐	☐
Anemia	☐	☐	Hay Fever	☐	☐	Pacemaker/heart surgery	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Psychiatric care	☐	☐
Artificial heart valves	☐	☐	Head injuries	☐	☐	Rapid weight gain/loss	☐	☐
Artificial/replacement joints	☐	☐	Heart murmur	☐	☐	Radiation treatment	☐	☐
Asthma	☐	☐	Heart problems	☐	☐	Respiratory disease	☐	☐
Atopic (Allergy Prone)	☐	☐	Please explain heart problems:			Rheumatic/Scarlet fever	☐	☐
Back problems	☐	☐				Shingles	☐	☐
Blood disease	☐	☐	Hemophilia	☐	☐	Shortness of breath	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Skin rash	☐	☐
Chemical Dependency	☐	☐	Hepatitis	☐	☐	Sinus problems	☐	☐
Chemotherapy	☐	☐	High blood pressure	☐	☐	Spine Bifida	☐	☐
Circulatory Problems	☐	☐	Human Papilloma Virus HPV	☐	☐	Stomach problems	☐	☐
Cortisone Treatments	☐	☐	Jaw pain	☐	☐	Stroke	☐	☐
Cough (present)	☐	☐	Jaundice	☐	☐	Surgical implant	☐	☐
Coughing up blood	☐	☐	Kidney disease	☐	☐	Swelling of feet/ankles	☐	☐
Diabetes	☐	☐	Liver disease	☐	☐	Thyroid disease	☐	☐
Dizziness	☐	☐	Material allergies (latex, wool, metal, chemicals)	☐	☐	Tonsillitis	☐	☐
Epilepsy	☐	☐				Tuberculosis	☐	☐
Fainting	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Food allergies	☐	☐	Mental disorders	☐	☐	Venereal disease	☐	☐

CONSENT FOR SERVICES

We are very happy to have you as a new patient in our office. At Airport Dental, we take a lot of pride in meeting or exceeding our patients' needs. This keeps us very busy, so we do require each patient to read and understand the following procedures that we follow.

As a condition of your treatment by this office, financial arrangements must be made in advance for any treatment to reserve the doctor's time. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment is provided. All same-day service, emergency dental service, or any other dental services performed without previous financial arrangements, must be paid for before these services are performed.

Again, because we want to best serve our patients, we adhere to a strict policy regarding no-show and cancelled appointments. If at least one business day (example: you must call Monday change/cancel a Wednesday appointment, must call Thursday to change/cancel a Monday appointment) is not given to change or cancel an existing appointment, you will be placed on 12-month probation. If another appointment is broken within that 12-month probationary period, you will be dismissed from the care of Bryan Gerstenberg, DDS at Airport Dental. We are sure you understand that when you miss appointment time reserved specifically for you, other patients in need of treatment cannot be seen. Notice of hospitalization, physician visit or recent death of family waives probation. In addition, if we are unable to make contact with you within two weeks of your scheduled appointment, Airport Dental reserves the right to double-book your appointment time.

Due to the cost of record duplication, Airport Dental charges $5.00-$20.00 per duplicated film radiograph and $0.15 per duplicated page from the chart, if requested by patient or another practitioner.

Patients who carry dental insurance are to understand that Dr. Gerstenberg is an out-of-network provider and all treatment proposals are presented with an estimate of what insurance will cover, not a guarantee. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. This office will electronically file most insurance forms and assist in making collections from insurance companies as a courtesy. Any such collections will then be credited to the patient's account and if there is a remaining balance, it is the responsibility of the patient. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Account balances aging over 90 days without payment or other financial arrangement are subject to being turned over to a local collections service. I also understand that the treatment plan costs listed for this dental care can only be extended for a period of 30 days from the date of the examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

______ I grant my permission to you or your assignee, to telephone, text and/or e-mail me to discuss matters related to this form, appointments and/or account balance.
initial I give my permission for this office to take video/photographs to be used for diagnostic, insurance and practice development purposes.

I have read the above policies, conditions of treatment and payment guidelines and agree to abide by them:

______________________________ Date: ____________ Relationship to Patient: ______________

Signature of patient, parent or guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the restriction that you requested. If we do agree to a restriction, we must abide by it, unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer."

Airport Dental
905 Garden Gate Circle
Pensacola, FL 32504
(850) 477-8668 office
(850) 477-0449 fax

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights.
A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I received a copy of Airport Dental's
Notice of Privacy Practices.

Signed: ______________________________ Date: __________________________

Print Name: _________________________ Telephone: ____________________

If not signed by the patient, please indicate relationship to patient:

____ Parent or guardian of minor patient
____ Guardian or conservator of an incompetent patient
____ Beneficiary or personal representative of deceased patient

Name of patient: ____

FOR OFFICE USE ONLY:

Signed form received by: ___________________________________

Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

905 Garden Gate Circle | Pensacola, FL 32504 | (850) 477-8668 office | (850) 477-0449 fax

AUTHORIZATION FOR DISCLOSURE OF YOUR PHOTOGRAPH AND RELATED INFORMATION SO THAT WE MAY PROCESS YOUR **FREE** LUMISMILE.

Name: ____

First Last

AUTHORIZES (RELEASE OF DENTAL INFORMATION FROM):
Airport Dental - Bryan Gerstenberg, DDS
905 Garden Gate Circle
Pensacola, FL 32504

RELEASE OF DENTAL INFORMATION TO:
LUMISMILE by DENMAT
2727 Skyway Drive
Santa Maria, CA 93455

LUMISmile photographs are representative of your new smile. Actual results may vary; this is not a guarantee.

INFORMATION TO BE RELEASED: One patient photograph and his/her name.

PURPOSE FOR NEED OF DISCLOSURE: CONTACTING YOU REGARDING LUMISMILE; SENDING AND TRACKING YOUR LUMISMILE AND RELATED MATERIALS BETWEEN AND AMONG YOU, YOUR DENTAL OFFICE, AND LUMISMILE BY DEN-MAT.

HIPAA PRIVACY RULE: CONSENT, INFORMATION DISCLOSURE, AND AUTHORIZATION
Right To Inspect or Copy The Health Information To Be Used Or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer listed below.

Right To Receive Copy Of This Authorization – I understand if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form.

Right To Refuse To Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.

Right To Withdraw This Authorization – I understand I can withdraw my authorization by sending written notice to the Privacy Officer at the address listed below, and I may contact the Privacy Officer to receive a copy of my withdrawal. I am aware my withdrawal will not be effective as to uses and/or disclosures of my health information that the Person(s) and/or organization(s) listed above have already made in reference to this authorization.

I acknowledge that the photograph to be released and related information may include material that is protected by federal law.

I acknowledge the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

____ ____________________

Signature of the Patient/Legal Representative Date