Teeth E*lite*
Eileen C. Golway, D.M.D., P.A.

6801 N.W. 9th Blvd.
Lower Level, Suite 3
Gainesville, Florida 32605

(352) 333-3683

Welcome to our office! **We hope you feel comfortable in our office setting and find our staff to be courteous and receptive to your needs. If you have any questions, please feel free to ask for assistance. Our office hours are from 8:00 a.m. to 5:00 p.m. Monday through Thursday, and on every other Friday 9:00 a.m. until 12:00 noon. However, no patients are seen on Fridays.**

Our goal is to provide you with high quality care at an economical price. We will file pre-authorizations and insurance claims for you, but we feel it is your responsibility to know the limits and coverage of your particular policy. We cannot keep up with the specific guidelines of every patient's policy, so we will practice dentistry to the best of our ability and make recommendations we think are in your best interest. <u>You are expected to pay your portion of the charges at the time services are rendered. If you have any questions please ask before you are seen by the doctor.</u>

Please be aware that we ask you to give us 24 hours notice if you need to cancel or reschedule your appointment. <u>If you do not show up for your appointment, or cancel the same day, there will be a $35.00 charge.</u> This policy allows us to make your appointment available to other patients wishing to be seen. All procedures are expected to be paid in full at the time of completion. To assist you in receiving care, we offer several payment options. You may choose to pay by cash, check, major credit card (Visa, Master Card, Discover), or we offer No Interest Payment Plans, in addition to Extended Payment Plans through Care Credit, a division of GE Consumer Finance. PLEASE make payment arrangements, if necessary, before beginning any treatment.

We look forward to meeting with you at your next appointment. If you would like dental information on a certain type of service, please feel free to ask. We will work hard to keep your smile healthy and bright!

_____ _____

Patient/Guardian Signature **Date**

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST / MI / LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

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6801 NW 9th Boulevard
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Patient name:_____Date:_____

Are You a Candidate For Cosmetic Dentistry?

Self-analysis:	**Yes**	**No**
1. Does your self-confidence lessen when smiling in front of other people?	___	___
2. Do you ever put your hand up to cover your smile?	___	___
3. Do you feel you photograph better from one side of your face?	___	___
4. Is there someone you think has a better smile than you?	___	___
5. Do you look at magazines and wish you had a smile as pretty as the model's smile?	___	___
6. When you read a fashion magazine, are your eyes drawn to the model's smile?	___	___
7. When you look at your smile in the mirror, do you see a minor defect in your gums or in any of your teeth?	___	___
8. Do you wish your teeth were whiter?	___	___
9. Do you wish your gums looked better?	___	___
10. Do you wish you showed more or fewer teeth when smiling?	___	___
11. Do you think you show too much or too little gum tissue when you smile?	___	___
12. Do you wish you had longer or shorter teeth?	___	___
13. Would you prefer wider or narrower teeth?	___	___
14. Are your teeth too square or too round?	___	___
15. Do you wish your teeth were shaped differently?	___	___

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CONSENT TO USE OR DISCLOSE DENTAL AND MEDICAL INFORMATION

I authorize *Eileen C. Golway, D.M.D., P.A.* to use and disclose the dental, medical, and health information of _____ for the following purpose(s):
(Name of Patient)

> Treatment -- includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.

> Payment -- includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and for clinical necessity, appropriateness of charges, pre-certification and preauthorization of services.

> Health Care Operations -- includes associated business and administrative affairs of this office.

You have the right to revoke this Consent. However, you must revoke this Consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within which this Consent is effective.

_____ _____ OR
Date Signature of patient

_____ _____
Date Signature of guardian or other person authorized by law