GUBLER PERIODONTICS
& IMPLANT SPECIALIST
MITCHELL M. GUBLER D.D.S., M.S.

Patient Information:

Last_____ First_____ Middle _____ Preferred_____

Gender: MALE / FEMALE Birth Date: _____ Marital Status: Married Single Child Other

Phone Numbers: Home_____ Cell_____ Work_____

Address: _____ City_____ State _____ Zip_____

Patient's Employer: _____ Patient's email address: _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency: _____ Phone: _____

Does patient have dental insurance? Y / N If yes, name of insurance company: _____

Full name of primary subscriber: _____

Social Security Number of subscriber (for insurance purposes): _____

Subscriber's date of birth: _____ Patient's relationship to subscriber: _____

Subscriber's employer: _____

Authorization:

I understand that I am financially responsible for all charges, whether or not I have insurance, and whether or not paid by insurance. Gubler Periodontics gives all patients an estimated cost of treatment. As a service to our patients, Gubler Periodontics will bill the insurance (if applicable) and payment is to be made to Gubler Periodontics unless otherwise specified. I understand that insurances differ in coverage, pricing, and allowable amounts.

By signing below, I understand that payment is due at the time of service.

I authorize Dr. Gubler and Gubler Periodontics to release all information necessary to secure payment of benefits.

I understand that Gubler Periodontics has a cancellation and no-show policy which enables them to charge me for a cancelled or missed appointment if within 24 hours of that appointment. The fee for cancellation or missed appointment within 24 hours is $50 for each hour that was reserved for my appointment.

Patient signature: _____ Date: _____

Guardian signature (if patient under 18 years of age): _____ Date: _____

368 E. Riverside Drive #7 St. George, UT 84790 • Phone 435.688.1344 Fax 435.688.1845
www.gublerperio.com • gublerperiodontics@gmail.com

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MEDICAL HISTORY

Patient Name_____Date_____DOB_____

Do you have or have you ever had any of the following:

Circle Yes or No Below

Yes No Allergic reaction to drugs or latex (circle all that apply)

Latex Penicillin Aspirin Codeine Local anesthetics Metal Other

Yes No Heart attack or heart disease

Yes No Stroke

Yes No High blood pressure

Yes No Congestive heart failure

Yes No Angina (Chest Pains)

Yes No Irregular heart beat

Yes No Rheumatic fever, rheumatic heart disease

Yes No Bacterial endocarditis (SBE)

Yes No Congenital heart disease

Yes No Heart murmur or mitral valve prolapse

Yes No Immunosuppressive condition (circle all that apply)

Steroid therapy Radiation therapy Chemotherapy SLE (Lupus) Rheumatoid Arthritis

HIV Organ transplant Spleen removed Other

Yes No Artificial joints (circle all that apply) Hip Knee Ankle Shoulder Other

Date(s) placed_____

Yes No Other implants or devices

Yes No Bleeding problem, anemia, other blood disease

Yes No Diabetes

Yes No Thyroid disease

Yes No Nervous system disease or seizures

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Yes No Stomach or intestinal disease

Yes No Kidney disease

Yes No Hepatitis (A, B, C, or D)

Yes No Other liver disease

Yes No Arthritis (osteo or rheumatoid)

Yes No Other muscle or joint disease

Yes No Mental health condition- please specify_____

Yes No Physical or mental disabilities that may require special care

Yes No Do you have or have you ever been treated for cancer?

Yes No Are you or could you be pregnant?

Yes No Are you nursing?

Yes No Do you have difficulty hearing?

Yes No Do you have any disease, condition, or problem not listed here?

Yes No Have you ever been hospitalized or had surgery? Describe_____

Yes No Do you have any undiagnosed problems? Describe_____

Yes No Are you or have you ever been addicted to a chemical substance?

Example: alcohol, prescription drugs, heroin, meth, cocaine, other

Yes No Do you smoke or use tobacco products?

How long have you used tobacco?

Type of tobacco?

How much do you use per day?

Are you interested in quitting? YES NO

Yes No Are you a PAST user of tobacco products?

Yes No Do you regularly take herbal medicines or dietary supplements? Please list them:

Yes No Have you undergone current or past osteoporosis therapy? (Fosamax, Actonel, Boniva Pill form)

Yes No Have you undergone current or past bisphosphonate therapy? (IV Aredia, Zometa)

Please list your family physician and any medical specialists you see at least once a year:

Name Address phone Specialty

_____

Please list all medications you are currently taking:

_____

_____

DENTAL HISTORY

What is your chief complaint? Why are you seeking dental care? _____

_____

Yes No Do you have regular dental checkups? Date of last exam_____

Yes No Have you had any trouble associated with previous dental treatment? If so, explain:

_____

Yes No Have you noticed any lumps or sores in your mouth?

Yes No Do your gums bleed when you brush or floss your teeth?

Yes No Do you suffer from pain in the mouth, face, eyes, neck, or throat?

Yes No Have you ever injured your face, jaws or teeth?

Yes No Has fear ever prevented you from seeking dental treatment?

Yes No Are you allergic to any metals or dental materials:

Please circle the types of dental treatment you have experienced:

Orthodontics (Braces) Dentures Root Canal Treatment Implants

Oral Surgery Periodontal (Gum) Treatment TMJ Fillings Crowns

Bridges Veneers Bleaching Other: _____

I acknowledge the above information to be correct and I understand that it is my responsibility to inform the office of any changes to my health as soon as possible.

Signed _____Date_____

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ATTENTION: Important Insurance Information

(Please read fully and carefully)

In order to prevent any future misunderstands, disagreements, or disappointments, it is vital that our patients understand our relationship with insurance companies. Please be aware that the dental insurance contract you have is between YOU and YOUR insurance company, not us and your company. We do not own, control, or influence insurance companies; thus, your company has the final decision as to what dental needs or treatment your policy will cover. Because of the complexities of dental insurance requirements, we provide assistance for you as a courtesy. However, the primary responsibility for dealing with your company is fundamentally yours, not ours. Disagreements and misunderstandings are not between this office and the insurance company; rather, they are between you and your insurance company. Your personal involvement will help to insure the best possible response and service. Your insurance company is far more likely to respond to requests or complaints directly from you rather than from us. After all, you are the one who pays the premiums, we are not.

In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance does not release you from your financial obligation to us. Since we have no association with insurance companies, we cannot guarantee, promise, or certify their actions or decisions. We will provide you with estimates of what your insurance company will cover based on the information they provide us. We will do everything in our power to help you to get the proper benefit, but ultimately the final decision rests with your insurance provider.

I have read and understand the above.

Signature _____ Date _____

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