Chad Gardner, DDS

NEW PATIENT INTAKE FORM

General & Family Dentistry · 625 S Washington St, Bastrop, LA 71220 · (318) 281-5972

PATIENT INFORMATION

Last name | First name | MI | Date of birth (MM/DD/YYYY)

Street address | City | State | ZIP

Cell phone | Home/other phone | Email

Sex: ☐ Male ☐ Female

Preferred contact: ☐ Call ☐ Text ☐ Email

How did you hear about us?

PARENT / GUARDIAN / RESPONSIBLE PARTY (REQUIRED FOR PATIENTS UNDER 18)

Full name | Relationship to patient | Date of birth

Phone | Address (if different from patient)

DENTAL COVERAGE

Check all that apply:

☐ Louisiana Medicaid — MCNA Dental (including EPSDT)

☐ Private dental insurance (PPO or other)

☐ No dental coverage / self-pay

☐ I'm interested in CareCredit financing

Note: We are out-of-network with all PPO plans, but we accept and file ALL dental insurance as a courtesy to our patients.

Medicaid / MCNA member ID | Patient's Medicaid DOB (if different)

Insurance company (if private) | Subscriber name | Subscriber DOB | Relationship

Subscriber ID # | Group # | Subscriber's employer

EMERGENCY CONTACT

Name | Relationship | Phone

MEDICAL HISTORY

Physician's name

Physician's phone

Date of last physical

Have you ever had, or do you currently have, any of the following? (check all that apply)

- ☐ Heart disease / heart attack
- ☐ High blood pressure
- ☐ Heart murmur / valve issue
- ☐ Artificial heart valve
- ☐ Pacemaker / defibrillator
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ Liver disease / hepatitis
- ☐ Asthma / breathing problems
- ☐ Tuberculosis
- ☐ Seizures / epilepsy
- ☐ Fainting spells
- ☐ Cancer / chemotherapy
- ☐ Radiation treatment (head/neck)
- ☐ Osteoporosis / bone meds
- ☐ Artificial joint (hip, knee, etc.)
- ☐ Bleeding disorder / anemia
- ☐ Blood thinners (any)
- ☐ HIV / AIDS
- ☐ Stomach ulcers / acid reflux
- ☐ Psychiatric / mental health care
- ☐ Substance use treatment
- ☐ Tobacco use (any form)
- ☐ Alcohol use (regular)
- ☐ Sinus problems

Women: ☐ Pregnant (due: _____) ☐ Nursing ☐ Taking oral contraceptives

Other medical conditions not listed above

Current medications (include dose — attach a list if easier)

Allergies:

- ☐ Penicillin / antibiotics
- ☐ Codeine / narcotics
- ☐ Local anesthetic (Novocain)
- ☐ Latex
- ☐ Aspirin / NSAIDs
- ☐ Sulfa drugs

Other allergies

DENTAL HISTORY

What brings you in today? (chief concern)

Are you in pain now? (Y/N + where)

Approx. date of last dental visit

Last dental X-rays

Previous dental office (name/city)

Check any that apply:

- ☐ Bleeding or sore gums
- ☐ Sensitivity to hot/cold/sweets
- ☐ Grinding or clenching
- ☐ Jaw pain / clicking (TMJ)
- ☐ Dry mouth
- ☐ Bad breath concerns
- ☐ Loose or shifting teeth
- ☐ Anxiety about dental visits
- ☐ Snoring / sleep concerns

CONSENT TO DENTAL TREATMENT

I authorize Dr. Chad Gardner and his staff to perform the dental examinations, diagnostic imaging (X-rays), and treatment procedures that are explained to me and that I accept. I understand that dentistry is not an exact science and that no guarantees can be made regarding outcomes. I understand I may ask questions and refuse any treatment at any time.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the practice of Chad Gardner, DDS, which describes how my health information may be used and disclosed and how I can access my information. My information will only be used or disclosed as permitted by law.

☐ I acknowledge receipt (or the offer) of the Notice of Privacy Practices.

May we discuss your care/appointments with anyone else? List name(s) and relationship (optional)

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the practice of Chad Gardner, DDS to release the information necessary to file claims with my dental benefit plan (including Medicaid/MCNA), and I authorize payment of benefits directly to the practice. I understand the practice is out-of-network with all PPO plans and files private insurance claims as a courtesy; I remain responsible for any balance my plan does not pay, unless my coverage (e.g., Medicaid/MCNA) provides otherwise.

FINANCIAL & APPOINTMENT POLICY

Payment (or my estimated portion) is due at the time of service. I understand the office asks for at least 24 hours' notice to cancel or reschedule an appointment so that time can be offered to another patient.

Signature of patient (or parent/guardian if under 18)

Relationship to patient

Date

If printing this form, please sign by hand above. If completing electronically, typing your full legal name serves as your signature acknowledgment; our front desk will ask you to confirm with a handwritten signature at your first visit.