Dr. Christopher Gartland, D.D.S.

501 S. Cherry St. Suite #230
Glendale, CO 80246
303-322-3272
GartlandFamilyDentistry@gmail.com
www.christophergartlanddds.com

Patient Information

Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ Birth Date: _____ SS#: _____

E-mail Address: _____

Address: _____

_____ _____ _____
City State Zip

Phone: _____ _____
Best Number to Reach You Other

Emergency Contact: _____ _____
Name Phone

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

Dr. Christopher Gartland, D.D.S.

501 S. Cherry St. Suite #230
Glendale, CO 80246
303-322-3272
GartlandFamilyDentistry@gmail.com
www.christophergartlanddds.com

Health History

Name_____

Yes No

☐ ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

If Yes, why? _____

☐ ☐ Are you currently taking any prescription or non-prescription medication?

If yes, please list: _____

☐ ☐ Have you ever been asked to take antibiotics before dental treatment?

☐ ☐ Do you use tobacco (smoke or chew)?

Are you allergic to or have you had any reactions to the following (check all that apply)?

☐ Local Anesthetic ☐ Sulfa ☐ Aspirin ☐ Penicillin

☐ Latex Rubber ☐ No allergies ☐ other: _____

Please indicate if you have experienced any of the following:

☐ Blood Disease ☐ Artificial Joints ☐ Asthma ☐ Cancer

☐ Diabetes ☐ Epilepsy ☐ Fainting ☐ Heart Disease

☐ Heart Murmur ☐ Hepatitis ☐ HIV / AIDS ☐ Liver Disease

☐ Pacemaker ☐ Stroke ☐ Respiratory Problems

☐ High Blood Pressure

☐ Other: _____

WOMEN ONLY

Please check if you are currently:

☐ Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Signature _____ Date_____

Dr. Christopher Gartland, D.D.S.

501 S. Cherry St. Suite #230
Glendale, CO 80246
303-322-3272
GartlandFamilyDentistry@gmail.com
www.christophergartlanddds.com

Authorization for Treatment

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs and/or other diagnostic aids deemed appropriate. I authorize the treatment of dental conditions by appropriate means by Dr. Christopher Gartland and/or members of his staff.

HIPPA Release Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). By signing this consent I authorize the office of Dr. Christopher Gartland to use and disclose my protected health information to:

- Third Party Payers (i.e. my insurance company) to obtain payment for services.
- Other medical or dental offices to assist with referrals for specialty treatment.
- Other offices as related to the day-to-day operations of the practice.

I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

Consent for Payment

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I may be billed for this remaining balance. All dental services must be paid in full at the time of service unless previous financial arrangements have been made. A service charge of 5% per month on the unpaid balance will be charged on all accounts exceeding 30 days unless previous financial arrangements are agreed upon or satisfied.

By signing, I acknowledge that I have read the above information and agree to the contents.

Signature: _____ Date: _____