Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient 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, or within five (5) days of billing if credit shall be extended. 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 be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Health Information

Patient Name:____ Date: ___________

Date of Last Dental Visit: __________________

Do you have any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ______________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _________________
- ☐ _________________

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, list medications: ____
  ____
  ____
  ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ________________________________ Phone: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ______________________
Signature of patient, parent or guardian

DO NOT SIGN BELOW UNLESS INSTRUCTED

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Health History: ☐ Corrected ☐ No Change

_________________________________ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments; however, we may not be a network provider for your plan. If we are not in network, review your plan details, as in many cases, insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please, understand you are responsible for all charges not paid by your insurance. Also, many insurance companies exclude certain dental procedures or downgrade procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Workers compensation** claims will be filed for you. Please, understand the carrier will assign a dollar amount that will be paid toward the claim, which may or may not cover the entire fee. Any amount not covered by the carrier will be your responsibility.
- **Minors must be accompanied by a parent or guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for any fees, deductibles, or co-payments at the time of service.

Payments

- **Patient portion and patient co-pay or deductible is due at the time services are rendered** unless prior financial arrangements have been made.
- **Payment Information:**
  - **-**The following major credit cards are accepted: Visa, MasterCard, Discover.
  - -A 3% processing fee will be applied for all payments charged as credit.
  - -Financing with CareCredit® is accepted.
  - -A 1.75% finance charge will be charged for late payments.
- **Balances left over 90 days will be turned over to a collection agency with an addition 50% collection fee added.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our office promptly for assistance in the management of your account.

Short Cancelled / Missed Appointments

- **Please give us 48 hour notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy in return.

By signing below I acknowledge I have read and understand all guidelines within the *Financial Guidelines* above.

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Acknowledgement of Privacy Practices

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or heath care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By signing below I acknowledge I have read and understand all the guidelines within the *Acknowledgement of Privacy Practices* above.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Patient Name: _____Date: _____
Last, First MI (Preferred Name)

Questionnaire

How did you hear about us? □ Facebook □ Phonebook □ Drive by □ Billboard □ Family/Friend
□ Internet Search (specify domain):_____

□ Other (explain):_____

Are you following us on social media? □ Yes □ No

If yes, specify:_____

Have you visited our website? □ Yes □ No

Social Media Consent Form

I hereby authorize Gautier Family Dental Care to obtain and/or publish digital imagining/audio, such as: photographs, video, and/or audio recording, of said patient for use in Gautier Family Dental Care's company publications including those that are printed, published online, and/or created in video form.

I attest that I have full authorization to consent to publication of these digital imaginings/audios. Further, I hereby release and hold harmless Gautier Family Dental Care from any reasonable expectation of privacy or confidentiality associated with the above-specified digital imagining/audio.

I further acknowledge that neither I nor any other party, who may share ownership of the property described above, whether in the past or future, will receive financial compensation of any type associated with the taking or publication of these digital imaginings/audios or participation in company publications. I acknowledge and agree that publication of said digital imaginings/audios confers no rights of ownership or royalties whatsoever and that participation is voluntary.

I hereby release Gautier Family Dental Care, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials from liability for any claims by be or any other party in connection with my participation.

Select one:

□ **I decline** authorization of any and all the terms listed in the social media consent.

□ **I agree** consent authorization of any and all the terms listed in the social media consent.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian