Patient Information (Confidential)

Name _____ ☐Male ☐Female Date of Birth ____/____/_____
Social Security # _____-_____-_____ Driver's License # _____
Address _____ City _____ State _____ Zip_____
Home Phone _____ Cell Phone _____
E-mail _____
Employer _____ Work Phone _____
Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Spouse or Parent/Guardian's Name _____ Phone # _____
Emergency Contact 1_____ Phone # _____
Whom May we Thank for referring you? _____

To whom may we speak to, other than you, about payment and account related details?
Name: _____
Relationship to patient: _____
Phone Number: _____

Insurance Information ***Complete the following if different than patient information** *

Name of Subscriber _____ Relationship to Patient _____
Name of Insurance _____ Phone # _____
Member ID# _____ Group # _____
Name of Employer _____ Phone # _____
Date of Birth ____/____/____ Social Security # _____-_____-_____ Driver's License # _____
Address _____ City _____ State _____ Zip_____
Home Phone _____ Cell Phone _____

TREATMENT PLANS ARE A NECESSITY

Beginning by scheduling an appointment in the hygiene department for necessary records. This enables the Dentist to do a complete evaluation. If you no show or cancel this appointment Goliad Dental and Dentists associated will be held harmless.

NOTICE OF PRIVACY PRACTICE

I have been provided with a copy of the notice of privacy practice or a copy has been made available to me at my request. A copy of the Notice of Privacy Practice has been given to me and by signing below; I acknowledge receipt of said notice and have carefully read and understood my rights pertaining to my medical information and how it may be disclosed.

AUTHORIZATION AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT unless prior arrangements have been approved. This office accepts insurance, I understand that I am responsible for payment of services rendered and also am responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ Date _____
Signature of patient (or parent/guardian)

Patient Medical History Age _____

Physician _____ Phone Number _____ Date of last exam _____

Preferred Pharmacy: _____ Pharmacy Phone Number:_____

Are you under medical treatment now? Yes No (If yes, explain) _____
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ? Yes No
(If yes, explain)_____
Have you ever taken Fen-Phen/Redux?.....Yes No Do you use controlled substances?.....Yes No
Do you use tobacco?.....Yes No
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?) Yes No

Do you have or had any of the following? ***Please Circle Yes or No***

High Blood Pressure.....	Yes	No	Heart Murmur.....	Yes	No	Tuberculosis.....	Yes	No
Heart Attack.....	Yes	No	Angina/Chest pains.....	Yes	No	Joint Replacement/Implant.....	Yes	No
Rheumatic Fever.....	Yes	No	Fainting/Seizures.....	Yes	No	Cancer.....	Yes	No
Heart Disease…….....	Yes	No	Epilepsy/Convulsion.....	Yes	No	Leukemia…….....	Yes	No
Cardiac Pacemaker.....	Yes	No	Lupus, Pemphigus.....	Yes	No	Radiation Therapy.....	Yes	No
Defibrillator.....	Yes	No	AIDS/HIV infection.....	Yes	No	Liver Disease…….....	Yes	No
Irregular Heartbeat….....	Yes	No	Cold Sore/Shingles.....	Yes	No	Hepatitis…. A…….B……C…...	Yes	No
Heart Surgery…….....	Yes	No	STD….....	Yes	No	Diabetes ……Type1....Type 2…	Yes	No
Artificial Heart Valves.....	Yes	No	Lung Disease.....	Yes	No	Kidney Disease.....	Yes	No
Stent….....	Yes	No	Asthma…….....	Yes	No	Thyroid Problem.....	Yes	No
Shunt…….....	Yes	No	Emphysema…….....	Yes	No	Arthritis/Gout……	Yes	No
Stroke…….....	Yes	No	Easily Winded……	Yes	No	Stomach trouble/Ulcers.....	Yes	No
Bacterial Endocarditis.....	Yes	No	Hay Fever/Allergies……....	Yes	No	Glaucoma……	Yes	No

Other:_____ Do you have Sleep Apnea or CPAP?_____

Please list all medications that you are currently taking: _____
_____

Please Circle any of the following that you are taking:

Cortisone Drugs	Steroids	Tranquilizers	Sedatives
Blood Thinners	Anticoagulants	Aspirin	Pradaxa
Warfarin	Coumadin	Xarelto	Eliquis

Do you take any osteoporosis or bisphosphonate medications? Please circle all that apply.

Actonel Aredia Boniva Fosamax Reclast Zometa Skelid Didronel Other:_____

Are you allergic to or do you suffer ill effects from any of the following? Please circle all that apply.

Penicillin	Codeine	Dental Anesthesia	Sulfa
Aspirin	Household Bleach	Latex	Other:_____

Are you pregnant? Y / N If yes: How many months? _____ Are you breast feeding? _____

The above information is true to the best of my knowledge.

Print Name _____Signature_____Date_____

Goliad Dental
703 S Goliad St
Rockwall, Texas 75087
Tel: 972-771-9131
Fax: 972-772-6980

Office Policies

Insurance:

In an effort to increase patient goodwill and maintain a high level of professional care, we would like to clarify our office policies and procedures as they relate to our patient's insurance.

1. If you have insurance, we will be happy to help you determine the coverage you have available.
2. We advise as accurately as possible from the benefits stated by your carrier or in your insurance booklet.
3. We cannot be responsible for the amount of money your insurance company pays on your claim.
4. Any portion not paid by your insurance is the patient's responsibility. Balances not paid within 60 days will incur a late charge of $50 a month until balance is paid in full.

Care is provided to you, our patient, and not an insurance company. Thus, the insurance company is responsible to patient, not our office and the patient is financially responsible to the Doctor. We will be glad to assist you in filing your insurance claims and answer any questions you may have.

Missed Appointments:

We understand that emergencies do come up and appointments cannot be kept sometimes. We try very hard to accommodate all our patients and give appointments when needed. However, due to the difficulty in filling appointments missed, we do insist that a 24-hour notice be given if an appointment must be cancelled or rescheduled. Notice not given can result in **$100.00** missed appointment fee.

Treatment:

We strive to give our patients the highest quality treatment that can be made possible. Should you require dental treatment, local anesthesia (injections/shots) may be necessary. Although very unlikely, complications can arise as a result of injections. Some of the more common complications are pain, infection, swelling, bleeding, bruising, discoloration and temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek or teeth. You will be given the opportunity to ask questions about your dental treatment prior to us starting any procedure. We feel that it is imperative that you have an absolute understanding about your treatment including the risks and hazards involved.

Payments of services rendered:

We are very aware of the high cost of dental treatment and strive to make it as easy on the family budget as possible. If you have insurance, we can accept assignment of benefits and have you pay your portion as treatment is rendered. Otherwise, all payments are expected in full at the time of treatment unless agreed upon prior to treatment, in writing, in the form of a Financial Agreement.

I have read the above policy, understand and hereby acknowledge and agree to all the terms and conditions. I have also received a copy of the office policies for my records.

_____ _____

Patient's Signature(or legal guardian) Date

Acknowledgement of Receipt

Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above. Please sign inside box below.

Patient or Legally Authorized Individual Signature

Print Patient's Full Name: _____

Date:_____