Patient Information (Confidential)

Name ____ ☐Male ☐Female Age ___________________
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
Name of Subscriber ____ Relationship to Patient ____________________
Name of Insurance ____ Phone # __________________________________
Member ID# ____ Group # ___________________________________
Name of Employer ____ Phone # __________________________________
*Complete the following if different than patient information *
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.

Initial ______

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.

Initial ______

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:______________________________

	Yes	No
Are you under medical treatment now?......................	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? (If yes, explain) ______________ ____	☐	☐
Have you ever taken Fen-Phen/Redux?.....................	☐	☐

	Yes	No
Do you use tobacco?...	☐	☐
Do you use controlled substances?...............................	☐	☐
Are you wearing contact lenses?..................................	☐	☐
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?...	☐	☐

Do you have or any of the following?

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

Other:____ Do you have Sleep Apnea or CPAP?________________________

Please list all medications that you are currently taking: ____

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Check any of the following that you are taking:

Yes	No		Yes	No		Yes	No	
☐	☐	Cortisone Drugs	☐	☐	Anticoagulants	☐	☐	Tranquilizers
☐	☐	Steroids	☐	☐	Blood Thinners	☐	☐	Sedatives
☐	☐	Aspirin	☐	☐	Pradaxa	☐	☐	Warfarin/Coumadin
☐	☐	Xarelto	☐	☐	Eliquis	☐	☐	Other/Generic

Are you allergic to or do you suffer ill effects from any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Penicillin	☐	☐	Codeine	☐	☐	Dental Anesthesia	☐	☐	Sulfa
☐	☐	Aspirin	☐	☐	Household Bleach	☐	☐	Latex	Other:________________________________		

Are you taking or have taken any of the following bisphosphonate medications? Please list oral medications & IV Therapy

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Reclast ☐ Zometa ☐ Skelid ☐ Didronel ☐ 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 $20 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 **$40.00** 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

____
Witness

TRUTH LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INSRANCE RATES AND INTEREST CHARGES	
Annual Rate Percentage (APR) for Purchases	15.00%
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rates shown.
Minimum Interest Charge	If you are charged interest, the charge will be no less than $1.00
FEES	
Late Charge	$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00
Non-Sufficient Funds (NSF) Fee	$25.00 per payment

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064 but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number
- The dollar amount of the suspected error
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you're not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if your explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have question about your bill, and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges of dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

____
Dental Entity Name

__________________________________ __________________________________
Signature Date

__________________________________ __________________________________
Account Name Address

A photocopy of this document may act as an original

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.

Patient or Legally Authorized Individual Signature

Date: Time:

Print Patient's Full Name: ____

Witness Signature:

Date: Time:

Social Media Use and Consent

Consent to Use and Disclose Treatment Information and Photographs for Social Media Purposes

We value patients' rights to privacy and confidentiality, and we take our responsibilities under HIPAA and the Texas Medical Records Privacy Act very seriously. The practice exercises great care in the use of patient images and patient identities to promote the practice via social media. Specifically, we pledge not to disclose and discuss:

- Your past, present or future physical or dental health or condition;
- Discriminatory or potentially negative information of a personal or professional nature, and
- Past, present, or future payment of your healthcare.

By signing below, you grant our office permission to use an approved photograph of yourself along with a brief approved description for promotional purposes via social media.

You understand that this authorization may be revoked at any time merely by notifying our office that you wish us to discontinue using your photograph(s) and brief description(s) for promotional purposes.

Finally, your willingness to participate in social media promotion will have no effect on the treatment you receive from our office and staff. If you decline to allow us to use your photograph(s) and description(s), your treatment or experience as a patient of our practice will not be affected.

Patient Signature

____

Printed Name

____

Date Signed

____