

Patient Information (Confidential)

Today's Date _____

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? _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Driver's License # _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____

Financial Institution _____ Employer _____ Work Phone _____

Is this person currently a patient in our office? Yes No

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.

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 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.

Signature of patient (or parent/guardian)

Patient Medical History

Age _____

Physician _____ Phone Number _____ Date of last exam _____

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

Do you have or any of the following?

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

Other: _____

Check any of the following that you are taking:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Drugs		Anticoagulants		Tranquilizers	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids		Blood Thinners		Sedatives	

Please list all medications that you are currently taking: _____

Check any of the following blood thinners that you are taking:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin		Pradaxa		Warfarin/Coumadin	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Xarelto		Eliquis		Other/Generic	

Please list all medications that you are currently taking: _____

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

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin		Codeine		Dental Anesthesia	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? _____

Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc.)? explain: _____

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

Print Name _____ Signature _____ Date _____

New Patient Dental Questionnaire

At Goliad Dental we would like to help each patient reach their dental goals. Please take a moment and provide us the following valuable information:

I entered this practice to obtain:

(Please check all that apply)

Comprehensive Exam of my entire mouth and a consultation concerning my treatment options.

Smile Design Consultation to learn more about my cosmetic treatment options.

Emergency Exam for a specific area of concern. **Are you in pain?** Yes No
Please describe:

2nd opinion concerning treatment options presented elsewhere.

Other: Please explain:

I would rate the value I place on my oral health as: Very Important to me
 Moderately important to me
 Very low importance to me

I would rate the condition of my teeth and gums: Very good
 Good
 Acceptable
 In need of treatment
 In need of extensive treatment

I would rate my previous dental experiences and quality of care:
 Exceptional
 Above average
 Average
 Below average
 Poor

I have concerns in pursuing future dental treatment: Yes No

My concerns are:

I am fearful of dental treatment. Please explain:
 Financial
 Scheduling concerns. Please explain:
 Other:

I consider my smile: Very appealing
 Nice
 Acceptable to me
 In need of improvement

Is there any further information about you that would help us to assist you more thoroughly?

Goliad Dental and Associates
Barney M. Barnhill, D.D.S.
703 S. Goliad
Rockwall, TX 75087
Tel: 972-771-9131

Notice of Privacy Practice

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.

Confidentiality Questionnaire

1. Please list the telephone numbers, if any, where you want to receive calls about your appointments, or general questions we may have for you regarding your account:

2. Can confidential messages (i.e. appointment reminders) be left on your listed home telephone answering machine or voicemail? YES____ NO_____

3. Can confidential messages (i.e. appointment reminders) be left on your office voicemail or answering machine? YES____ NO_____

4. To whom may we speak to, other than you, about payment and account related details?

Name: _____ Relationship to

patient: _____

Phone: _____

PATIENT/GUARDIAN SIGNATURE

DATE

Goliad Dental
703 S. Goliad
Rockwall, TX 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 30 days will incur a late pmt fee 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 the 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 a **\$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 or 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 Arrangement.

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

Patient's Signature (or legal Guardian)

Date

Witness



Barney M. Barnhill
 703 S Goliad St.
 Rockwall, Tx 75087
 972-771-9131 .
www.goliaddental.net

A Smile is Forever

Date: _____

Answering these questions could save your life or life of someone you love!

Patient Name: _____

D.O.B.: _____

Primary phone contact: _____

Referral: _____

Alternate Phone: _____

Physician: _____

Have you had a sleep study done? _____

Dentist: _____

When? _____

Do you have someone to observe you sleeping? _____

<i>Lifesaving questions, answer to the best of your ability.</i>	YES	Seldom	Never	Not sure
Do you wake up tired and unrefreshed?				
Do you ever snore?				
Have you or your bed partner observed that you stop breathing or gasp for breath while sleeping?				
Do you doze off while watching TV, driving, reading, or performing daily activities?				
Do you ever wake up out of breath or choking?				
Are you a restless sleeper?				
Do you have joint aches?				
Do you have backaches?				
Do you have headaches? If so, how often?				
Do you have indigestion or acid reflux?				
Do you have or have you ever had high blood pressure?				
Have you ever had high cholesterol?				
Have you ever had heart problems?				
Do you have night sweats?				
Do you sleep on your back?				
Does your snoring awaken your bed partner?				

Notes: _____

TRUTH LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Rate for purchases	Percentage (APR)for 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 rate 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 a 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 for 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.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Dental Entity Name

Signature

Date

Account Name

Address



Acknowledgement of Receipt Consent to Use And Disclosure of Protected Health Information

Notice of 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: