PATIENT HIPAA CONSENT FORM

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 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Pratices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

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Gulf Coast PERIODONTICS
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Welcome to Our Office

Date: _____

First Name: _____ Last Name: _____

Patient Information

Address: _____ Address 2: _____

City: _____ State/Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○Male ○Female Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed

Birth Date: _____ Age: _____ Soc. Security: _____ Drivers License: _____

Emergency Contact Name: _____ Phone Number: _____

E-mail: _____ ○ I would like to receive correspondence via e-mail

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Security: _____ Drivers License: _____

○Responsible Party is also a Policy Holder for Patient ○Primary Insurance Holder ○Secondary Insurance Policy Holder

Employment

Employment Status: ○Full Time ○Part Time ○Retired

Student Status: ○Full Time ○Part Time

Preferred Dentist: _____

Employer: _____ Preferred Pharmacy: _____

Occupation: _____ Preferred Physician: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ○Self ○Spouse ○Child ○Other

Insured Soc. Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ○Self ○Spouse ○Child ○Other

Insured Soc. Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Medical History

PATIENT NAME:_____ **DATE:**_____

Although dental therapy primarily involves treating the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you receive. Thank You for answering the following questions.

Are you under a physician's care now? O Yes O No With Whom?_____
Have you ever been hospitalized or had a major operation? O Yes O No_____
Have you ever had a serious head or neck injury? O Yes O No _____
Are you taking Any Medications, Pills, or Drugs? O Yes O No Please List them:_____
_____
_____

Do you take, or have you taken, Bisphosphonates? O Yes O No _____

Are you on a special diet? O Yes O No _____
Do you use Tobacco? O Yes O No How much per day? _____
Do you use controlled Substances? O Yes O No_____

Women are you: O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives? O N/A

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Fentanyl O Versed/Midazolam
O Lortab O Vicodin O Other: _____

Do you have, or have you had, any of the following?

O AIDS/HIV Positive	O Chest Pains	O Frequent Headaches	O Irregular Heartbeat	O Scarlet Fever
O Alzheimer's Disease	O Cold Sores/Fever Blisters	O Genital Herpes	O Kidney Problems	O Shingles
O Anaphylaxis	O Congenital Heart Disease	O Glaucoma	O Leukemia	O Sickle Cell Disease
O Anemia	O Convulsions	O Hay Fever	O Liver Disease	O Sinus Trouble
O Angina	O Cortisone Medicine	O Heart Attack/Failure	O Low Blood Pressure	O Spina Bifida
O Arthritis/Gout	O Diabetes	O Heart Murmur*	O Lung Disease	O Stomach/Intestinal Disease
O Artificial Heart Valve*	O Drug Addiction	O Heart Pace Maker*	O Mitral Valve Prolapse*	O Stroke
O Artificial Joint*	O Easily Winded	O Heart Trouble Disease	O Pain In Jaw Joints	O Swelling of Limbs
O Asthma	O Emphysema	O Hemophilia	O Parathyroid Disease	O Thyroid Disease
O Blood Disease	O Epilepsy or Seizures	O Hepatitis A	O Psychiatric Care	O Tonsillitis
O Blood Transfusion	O Excessive Bleeding	O Hepatitis B or C	O Radiation Treatments	O Tuberculosis
O Breathing Problem	O Excessive Thirst	O Herpes	O Recent Weight Loss	O Tumors or Growths
O Bruise Easily	O Fainting/Dizzy Spells	O High Blood Pressure	O Renal Dialysis	O Ulcers
O Cancer	O Frequent Cough	O Hives or Rash	O Rheumatic Fever*	O Venereal Disease
O Chemotherapy	O Frequent Diarrhea	O Hypoglycemia	O Rheumatism	O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No_____
Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____

*Condition may require medication

Blood Pressure _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Dr. Heard of any changes in medical status.

_____
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

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Patient Registration & Financial Responsibility Agreement

We are honored you have chosen us for your dental care. In order to keep a completely professional and up front business relationship with our patients, we ask that you read and state that you understand our registration paperwork, payment policy and insurance policy.

As per your dentist's request, we have you scheduled for an initial consultation visit on:

Day: _____ Month: _____ Time: _____ am / pm

Please take a few moments to complete the patient registration forms and bring it all with you on the day of your appointment.
We would also like you to arrive 20 minutes prior to your scheduled appointment.
Please do not fax or e-mail us your patient registration paperwork. We also ask that you bring the following items or information with you:

1) Recent x-rays from other dentists
   (Please verify with your Dentist 's office that x-rays have been sent)
2) A list of your current medication
3) A list of all previous surgeries
4) A list of known allergies and/or medication sensitivities
5) All your current insurance cards or most recent explanation of benefits

If you need a new set of registration papers or more information you can visit our website www.gulfcoastperiodontics.com.

We ask that all patients be directly responsible for all charges in full, at the time of service . This includes the exam, x-rays & all procedures necessary.

Payment Options:

1) Cash
2) Check
3) Credit Card (Visa, Master Card, Discover & American Express)
4) Care Credit (Can be used as a payment plan & information is available upon request)

If you are planning on using a Credit Card or Health Savings Account card we ask that you know your available credit in advance to your appointment.

See reverse →

We realize that every person's financial situation is different . For this reason, we are a Care Credit provider. If interested, we can give you more information on Care Credit and the payment plans they provide. We also carry Care Credit applications and can walk you through the application process here in the office. After being approved for a Care Credit account, you may be able to use the account to pay for services that same day as long as the balance is not more than $1,000.00. You can also visit Care Credit.com for more information and to apply.

I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Dr. Rick Heard and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me.

As a courtesy, we will handle & file your dental insurance claims when provided with proper insurance information. We will not accept or file medical insurance, Medicaid or Medicare. The reimbursement allowed from the insurance company will be mailed in check form to the patient.

At the time of your appointment we need :

1) A copy of your dental insurance card or most recent explanation of benefits
2) The name of the primary person insured
3) The name of the employer with whom the insurance is secured
4) The date of birth of the primary on the insurance
5) The social security number of the primary on the insurance

If you are unaware of your dental insurance benefits, please call your insurance company before your appointment.

We are happy for the opportunity to provide you with optimal dental care and look forward to a long, productive relationship. You can remain confident that your care will always be our highest priority. ***If you have any questions, please do not hesitate to call us at your convenience. (361) 573-1014***

Please sign and date that you understand and agree to our policies. If there are any questions please ask us before signing.

_____

Print name

_____ _____

Signature Date