

# Keith Gaught, DDS, PA

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## Welcome to our Practice

Chart#: \_\_\_\_\_  
FOR OFFICE USE ONLY

Patient Name: \_\_\_\_\_  
Last First MI Preferred Name

Title: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ Prev. Visit: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Mobile Work Ext Fax Other

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

## Employment Information

The following is for:  the patient  the person responsible for payment  both  not applicable

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

## Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for:  the patient's spouse  the person responsible for payment  both  neither-not applicable

Name: \_\_\_\_\_  
Last First MI Preferred Name

Title: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Mobile Work Ext Fax Other

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

### Primary Dental Insurance:

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insurance Company Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Insurance Authorization:

- By checking this box,  
I authorize my insurance company to pay the dentist all insurance benefits rendered.  
I authorize the use of this electronic signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure the payment of benefits.  
I understand that I am financially responsible for all charges whether or not paid by insurance.

### Dental Information

What is your immediate concern?

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Previous Dentist Name and Phone Number:

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Date of most recent dental exam and dental x-rays:

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### Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% 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 any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

\* **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

### HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

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\* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

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Response Date: \_\_\_\_\_