Patient Information

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Keith RR Gaught DDS
FAMILY DENTISTRY

Patient Information

Patients First Name *

Patients Last Name *

MI

Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

○ Male ○ Female

Family Status

○ Married ○ Single ○ Child
○ Other

Patients Date of Birth *

__/__/____

Email *

Social Security Number (needed for insurance)

Address *

City *

State *

Zip Code *

____

Home Number

(___) ___-____

Mobile Number

(___) ___-____

Whom may we thank for referring you to our practice?

In an emergency who should be notified?

Emergency Contact

Phone Number

(___) ___-____

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Responsible Party Information

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

The following is for: *

○ the patient ○ the person responsible for payment ○ both ○ neither-not applicable

First Name

Last Name

MI

Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

○ Male ○ Female

Family Status

○ Married ○ Single ○ Child
○ Other

Date of Birth

__/__/____

Email

Social Security Number

___-__-____

Home Phone

(___) ___-____

Mobile Phone

(___) ___-____

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Primary Dental Insurance

We are dedicated to working with you to achieve your dental goals, and strive to maximize any dental insurance coverage you may have. In order to accomplish this, we request your dental insurance information 2 business days prior to your appointment.

We do need ALL the information listed. *If we do not have this information, we will ask that you* ***pay in full*** *for your dental services. We do not participate with any dental plans as a preferred provider or an in-network provider. We treat our patients with a high level of care, and it is our goal to ensure that we achieve this as seamlessly as possible.*

I was previously contacted by the office regarding my dental insurance

○ Yes ○ No

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.

What is your immediate concern?

Previous Dentist Name

Phone Number

(___) ___-____

Date of recent dental exam:

mm/dd/yyyy

Date of recent dental x-rays:

mm/dd/yyyy

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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. *

for the Administration Form.

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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.)

First Name *

Last Name *

Relationship to Patient *

☐ 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. *