

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

 Male  Female

 Single  Married Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_

Address:  \_\_\_\_\_\_\_\_\_\_

Street Apt

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

City State Zip Code

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home):  *\_\_* \_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Referral Information

Whom may we thank for referring you to our practice?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

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

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

Date of Last Dental Visit:

**Have you ever had any of the following? Please check those that apply:**

|  |
| --- |
| AIDS/HIV |
| Allergies \_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_ |
| Anemia |
| Arthritis |
| Artificial Joints |
| Asthma |
| Blood Disease |
| Cancer |
| Diabetes |
| Dizziness |
| Epilepsy |
| Excessive Bleeding |
| Fainting |
| Glaucoma |
| Growths |
| Hay Fever |
| Head Injuries |
| Heart Disease |
| Heart Murmur |
| Hepatitis |
| High Blood Pressure |
| Jaundice |
| Kidney Disease |
| Liver Disease |
| Mental Disorders |
| Nervous Disorders |
| Pacemaker |
| Radiation Treatment |
| Respiratory Problems |
| Rheumatic Fever |
| Rheumatism |
| Sinus Problems |
| Stomach Problems |
| Stroke |
| Tuberculosis |
| Tumors |
| Ulcers |
| Venereal Disease |
| Codeine Allergy |
| Penicillin Allergy |
| Other: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

• Are you taking any medication?  Yes  No

If yes, please explain:

• Are you allergic to any medication?  Yes  No

If yes, please explain:

• Do you have any history of a major illness?  Yes  No

If yes, please explain:

• Have you had any major operations?  Yes  No

If yes, please explain:

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain:

• (Women Only) Are You:

Pregnant  Yes  No

Nursing?  Yes  No

Taking birth control pills?  Yes  No

## Consent for Services

As a condition of treatment by Gateway Dental, financial arrangements must be made in advance. Gateway Dental 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.

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. Gateway Dental 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, Gateway Dental cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize Gateway Dental to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date



**FINANCIAL POLICY**

Welcome! Thank you for selecting *Gateway Dental* as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

**FINANCIAL AGREEMENT:**

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard or Discover. We also offer CARECREDIT and SPRINGSTONE, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. (There will be a fee for any additional procedure NOT included in the original treatment plan.)

**Optional payment term:**

1. Full pay cash discount: We offer a 5% accounting courtesy for all services over $500 that is paid in full prior to the commencement of services.
2. Full pay credit discount: We accept full or partial payment by Visa, MasterCard or Discover. If you choose to prepay for services over $500 using Visa or MasterCard, we can extend a 3% courtesy discount (sorry this discount does not apply to the Discover Card)
3. Term Loan: By arrangements with CARECREDIT and/or SPRINGSTONE we can offer patients upon approval, an interest-free term loan with no down payment, no annual fee and no prepayment penalty. Please ask us for an application.

**Appointments:**

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hour notice for cancelling an appointment. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

**Insurance Information:**

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January-December) **All of our doctors will diagnose treatment based on your dental health not your dental insurance coverage.**

You must realize that:

Dental insurance isn’t really (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person’s necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay; however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

***Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.***

**Patient’s Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**



ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDMENT\*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

Please Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* Individual refused to sign
* Communications barriers prohibited obtaining the acknowledgement
* Any emergency situation prevented us from obtaining acknowledgement
* Other (please specify)