A TRADITION OF EXCELLENCE

MEMBER AMERICAN DENTAL ASSOCIATION
MEMBER AMERICAN ACADEMY OF COSMETIC DENTISTRY
MEMBER ACADEMY OF GENERAL DENTISTRY

PATIENT INFORMATION

(PLEASE PRINT) DATE ____________

NAME ______________________ HOME PHONE ____________ CELL PHONE ____________

ADDRESS ______________________ CITY ____________ STATE ________ ZIP ________

SOCIAL SECURITY # ______________________ DOB ____________

CHECK APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT OR PARENT'S EMPLOYER ______________________ WORK PHONE ____________

SPOUSE OR PARENT'S NAME ______________ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ______________ CITY ____________ STATE ________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________________ PHONE ____________

EMAIL: ______________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________ RELATIONSHIP TO PATIENT ____________

ADDRESS ______________________ HOME PHONE ____________

SOCIAL SECURITY # ______________ BIRTH DATE ____________ BANK ____________

EMPLOYER ______________________ WORK PHONE ____________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ____________

BIRTH DATE ____________ SOCIAL SECURITY # ______________ DATE EMPLOYED ____________

NAME OF EMPLOYER ______________________ WORK PHONE ____________

ADDRESS OF EMPLOYER ______________ CITY ____________ STATE ________ ZIP ________

INSURANCE COMPANY______________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ______________ CITY ____________ STATE ________ ZIP ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ____________

BIRTH DATE ____________ SOCIAL SECURITY # ______________ DATE EMPLOYED ____________

NAME OF EMPLOYER ______________________ WORK PHONE ____________

ADDRESS OF EMPLOYER ______________ CITY ____________ STATE ________ ZIP ________

INSURANCE COMPANY______________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ______________ CITY ____________ STATE ________ ZIP ________

- FORM #26711 - CPG - (337) 365-6653

I understand that where appropriate, credit bureau reports may be obtained.
Please indicate preferred method of payment:

1. ☐ Cash or Check at time off appointment.
2. ☐ Visa, Discover, or MasterCard

X ______________________ Date: ____________

A TRADITION OF EXCELLENCE

GARY FAMILY DENTAL

MEMBER AMERICAN DENTAL ASSOCIATION
MEMBER AMERICAN ACADEMY OF COSMETIC DENTISTRY
MEMBER ACADEMY OF GENERAL DENTISTRY

PATIENT HEALTH RECORD

(PLEASE PRINT)

Physician's Name ______________________ Date of last visit ______________

Physician's Phone Number ______________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition		
AIDS	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Arthritis, Rheumatism	☐ YES	☐ NO
Artificial Heart Valve	☐ YES	☐ NO
Artificial Joints	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO
Bleeding abnormally, with extractions or surgery	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO
Circulatory Problems	☐ YES	☐ NO
Congenital Heart Lesions	☐ YES	☐ NO
Cortisone Treatments	☐ YES	☐ NO
Cough, Persistent or Bloody	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO
Do you wear Contact lenses?	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Fainting or dizziness	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO
Type ______		
Herpes	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
HIV Positive	☐ YES	☐ NO
Jaundice	☐ YES	☐ NO
Jaw Pain	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Liver Disease	☐ YES	☐ NO
Low Blood Pressure	☐ YES	☐ NO
Mitral Valve Prolapse	☐ YES	☐ NO
Nervous Problems	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO
Women:		
Are you pregnant?	☐ YES	☐ NO
Due date ______		
Are you nursing?	☐ YES	☐ NO
Psychiatric Care	☐ YES	☐ NO
Radiation Treatment	☐ YES	☐ NO
Respiratory Disease	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO
Scarlet Fever	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Sinus Trouble	☐ YES	☐ NO
Skin Rash	☐ YES	☐ NO
Special Diet	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Swelling of Feet or Ankles	☐ YES	☐ NO
Swollen Neck Glands	☐ YES	☐ NO
Thyroid Problems	☐ YES	☐ NO
Tonsillitis	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO
Tumor or growth on Head or neck	☐ YES	☐ NO
Ulcer	☐ YES	☐ NO
Venereal Disease	☐ YES	☐ NO
Weight Loss, Unexplained	☐ YES	☐ NO

MEDICATIONS

List Medications you are currently taking:

____

____

____

Pharmacy ______________________

Phone ______________________

ALLERGIES

Aspirin

Local Anesthetic

Barbiturates (sleeping pills)

Penicillin

Codeine

Sulfa

Iodine

Latex ______

Other ______

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ YES ☐ NO

For what condition? ______________________

Are you taking any new medications? ______ If so what? ______________________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Medical Release: I understand that the information contained in my case is confidential. However, I give my consent for Dr. Gary to release to my physician any information, which may be helpful in his/her understanding of my present health situation.

Patient signature: ______________________

A TRADITION OF EXCELLENCE

MEMBER AMERICAN DENTAL ASSOCIATION
MEMBER AMERICAN ACADEMY OF COSMETIC DENTISTRY
MEMBER ACADEMY OF GENERAL DENTISTRY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

401 NORTH LEWIS STREET
NEW IBERIA, LA 70563

OFFICE (337) 367-2228
FAX (337) 365-8378

DR. GARY AND YOUR INSURANCE PLAN-HOW THEY WORK TOGETHER

The staff at Dr. Gary's is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payments by a given company, they do change therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you a more accurate out of pocket figure you may require.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining the Dr. Gary family, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Dr. Gary reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Dr. Gary does request payment in full for your portion at the time of service. We accept Master Card, Visa, American Express, and Discover. If you are in need of an extended finance option, we also work with Care Credit, who offers six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs. Just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read and understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dr. Gary's.

SIGN____ DATE__________________

A TRADITION OF EXCELLENCE

MEMBER AMERICAN DENTAL ASSOCIATION
MEMBER AMERICAN ACADEMY OF COSMETIC DENTISTRY
MEMBER ACADEMY OF GENERAL DENTISTRY

BROKEN APPOINTMENT POLICY

We are pleased to welcome you to our practice. Please take a moment to familiarize yourself with this policy.

We strive to schedule appointments that are convenient for you. Since we try to accommodate so many busy schedules, it can be a very difficult task. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives other patients from receiving needed dental care. Our office is maintained on a schedule, therefore if you are unable to keep an appointment, a 24 hour advance notice would be appreciated. This allows the staff time to schedule a patient in need of dental carc.

A parent or legal guardian must accompany any child under the age of 18 to all appointments. Coming in 15 minutes late for any appointment may require rescheduling so we do not keep other patients waiting. A call would be appreciated if you are going to be late, we will do our best to work you into the schedule. If for any reason you fail to come or cancel last minute it may result in a broken appointment fee. We understand that emergencies arise unexpectedly and we will carefully assess each instance before applying any broken appointment fees.

The confirmation call from our office is a courtesy to our patients. It is **NOT** mandatory. It is the patient's responsibility to know when their appointment is and to call us with reasonable notice, 24 hours, if it is to be canccled or changed. We have the right to charge a fee for missed/broken or last minute canceled appointments. If after 3 missed/broken appointments the office reserves the right to not schedule any subsequent appointments.

I'm sure you understand that we must have policies along these lines. We appreciate you as our patient and thank you in advance for understanding our policy.

I, the undersigned, have read and understand the above policy. I agree to pay any fees that may be charged, should I fail to keep an appointment with out giving a 24 hour notice.

______________________________ ____________

Patient/Guardian Name **Date**

401 NORTH LEWIS STREET
NEW IBERIA, LA 70563

WWW.NEWIBERIADENTIST.COM

OFFICE (337) 367-2228
FAX (337) 365-8378