Insurance Information

Primary

Name of Insured: _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

Secondary

Name of Insured: _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

Responsible Party Information

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work):_____

Address: _____

_____

Patient Information

Patient Name: _____ I prefer to be called: _____ Date: _____
First MI Last

Gender: M F

Status (please circle one) M S D W O

Social Security #: _____ Birth Date: _____

Phone (Cell): _____ (Home): _____ (Work): _____

Email: _____

Mailing Address: _____

_____

Emergency Contact: _____ Phone: _____ _____ Relationship: _____

Health Information

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

- ☐ AIDS/HIV
- ☐ Allergies(please list) _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Clicking/Popping Jaw
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Migraine
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Please list all current medications:

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I received and reviewed Gold Canyon Dentistry Privacy Policy Notice.

Patient's Signature: _____ Date: _____

Missed Appointment Policy

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we ask that you allow 24 hours minimum for cancelled appointments, failure to do this, or "No Show" appointments will be charged a fee of $42. Thanks for your cooperation helping offer appointments in a timely manner.

Signature: _____ Date: _____

Financial Agreement

This office is happy to cooperate with individuals who have dental insurance. Our office will file your claims with your primary insurance carrier. Your dental insurance company is under contract with you and your employer. We ask that you read your policy and understand all limitations of your benefits. Please call your insurance agent if you have any questions. YOU ARE ultimately responsible for cost related to your care.

- The fees charged to insured individuals are our Usual and Customary Fees.
- If you do not have insurance, you will be expected to pay in full at time of service. We accept MC, Visa, Discover, Care Credit, Check, and Cash.
- We require your co-payment on the day of your dental services as contracted by your insurance provider.
- After insurance benefits have been paid; any unpaid balance is your responsibility. Balance after 90 days will accrue a 1.5% per month interest charge.
- If you are in default, the entire unpaid balance, and any collection fees will become immediately due and transferred to a collection agency.
- We wait 30 days for your insurance company to pay your claim. If your insurance company fails to pay or rejects your claim we require you to pay the balance in full and seek reimbursement from your insurance company. A fee will be added to your account if collections proceedings are retained.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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.

Signature: _____ Date: _____

Request for Records

All x-rays provided by GCD and taken by GCD become office record of GCD. We will not release original records. Duplicates may be requested with written consent on file.

Signature _____ Date: _____