



Patient Information (Confidential)

Name : _____ Preferred Name : _____

Birthdate _____ Male ___ Female ___ Social Security#: _____

Home#: _____ Cell#: _____ Work#: _____

Email: _____

Preferred ContactMethod: _____ Text OK? Yes or No

Address: _____

City _____ State _____ Zip Code _____

___ Single ___ Married ___ Divorced ___ Widowed

Name of Spouse _____

Are any Other family members patients at Galdos Dental ? YES ___ NO ___

How do you plan to take care if this account? Cash/Credit Card?/ Care Credit/ Lending Club ?

How did You hear about us? _____

Nearest Person not living with you whom we may call in case of an emergency:

Name: _____ Relationship _____ Phone: _____

INSURANCE: leave blank if you have no insurance

Name of insured _____ Birthdate _____

Relationship to patient _____ social security _____

Name of employer _____

Insurance Company _____ Phoe Number _____

Group # _____ Indetification /Member # _____

Insurance Co.Address _____

City _____ State: _____ Zip Code _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to child or me during the period of such dental care to third party payers and / or health practitioners. I understand I am responsible for any and all payments through the service of a collection agency, I shall be responsible for any incidental expenses, including collection cost/attorney fees.

Patient (or Guardian) _____ **Date:** _____

Galdos Dental Medical History

Patient Name (PRINT) _____

Date of Birth _____ Age _____ Weight _____ (lbs) Height _____

1. Have you been hospitalized or under the care of a **medical doctor** during the past two years? Reason? _____

2. **List medications** taken the past two years and reason: _____

3. **List allergy** (i.e., itching, rash, swelling, vomiting) to latex, penicillin, aspirin, or any other medication: _____

4. **CIRCLE** any of the following you have or have had:

Heart Attack/Disease	Inherited Condition/Birth Defect	Rash/Hives/Eczema/Skin Problem
Heart Failure/CHF	Sickle Cell Disease	Glaucoma
Heart Surgery/Stent	Anemia/Blood disorder	Impaired Hearing/Vision/Speech
Angina Pectoris (Chest Pain)	High/Low Blood Pressure	Psychiatric Treatment
Heart Murmur	Transfusion/Receiving Blood Product	Nervous/Anxiety Disorder
Congenital Heart Defect	Diabetes Type 1 / 2	Fainting/Dizzy Spells
Pacemaker	Hyper/Hypoglycemia	Sinus Problems/Infections
Artificial Heart Valve	MRSA (methicillin resistant staph)	Epilepsy/Seizures
Bacterial Endocarditis	Hemophilia	Steroid Therapy
Stroke/Aneurysm	Gastroesophageal Reflux	Current or Previous Tobacco Use
Rheumatic Fever	Stomach Ulcers	Sexually Transmitted Disease
Tuberculosis (TB)	Organ Transplant	AIDS Related/HIV
Sarcoidosis	Artificial Joint	Alcoholism
Emphysema	Tumor	Recreational Drug Use/Addiction
Asthma/Airway Disease	Cancer Type: _____	Vaping
Hepatitis/Jaundice/Liver Disease	Chemotherapy/Radiation	Allergies – Food, Metal, Etc.
Thyroid/Pituitary Disease	Arthritis/Scoliosis/Joint Problem	Cankers/Cold Sores/Apthous Ulcer
Cystic Fibrosis	Bladder/Kidney Disease	Eating Disorder/Special Diet
Chronic Obstructive Pulmonary Disorder		Sexual Enhancement Drugs (ie. Viagra)

5. Ever been victim of **abuse** or neglect (physical, emotional, psychological, sexual)? _____

6. Ever had a reaction to or problem with an **anesthetic**? _____

7. Can you **walk a flight of stairs** without exhaustion or needing a break? Yes or No?

8. Any significant medical history not listed above that the **dentist** should be told? _____

9. **Women:** Pregnant? Yes or No? Is there a possibility you are pregnant? Yes or No?

Nursing? Yes or No? Birth Control? Yes or No?

To the best of my knowledge all of the preceding answers are true and correct. I will notify my provider at next visit if there has been any change.

Date

Signature of Patient or Guardian

Signature of Doctor _____ Date : _____

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged \$50.00 Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

PAYMENT: FULL PAYMENT is due at the time of service.

Please indicate below the form of payment you wish to choose.

- Cash or check
- Visa, MasterCard, Discover
- If you qualify, a monthly payment plan is available for your convenience.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient Signature _____ Date: _____

Galdos Dental

Acknowledgement of receipt of notice of privacy practice

May refuse to sign

I, _____ (PRINT NAME), Have received a copy of this office notice of practices

Signature: _____ Date: _____

Whom may we release both your medical & account information to: (Parents, Spouse, Siblings, Dentist, Personal Email Etc.) Please be Specific:

Name

Relationship

For office use only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency prevented us from obtaining the acknowledgement

Other

Employee Signature _____ Date: _____

- NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable deferral and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we charge you \$25.00 to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information list at the end of this notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to the alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your health information in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.