Patient Information

Name _____ DOB _____-_____-_____ SS# _____

Address _____ City _____ ST _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

How did you hear about our office? _____

Patient Medical History

Do you have history of:	Y	N		Y	N		Y	N
Heart Disease			Diabetes			Cancer		
Heart Murmur			Arthritis			Osteoporosis		
Rheumatic Fever			Anemia			HIV/Aids		
Mitral Valve Prolapse			Thyroid Disease			Ulcers/Stomach Problems		
Pace Maker			Lung Disease			Cholesterol		
Stroke			Liver Disease			Sinus Problems		
High Blood Pressure			Hepatitis A,B,C			Drug Addiction/Alcoholism		
Low Blood Pressure			Kidney Disease			Other:		
Aspirin Therapy			Epilepsy/ Seizures					

Are you pregnant? _____
Do you snore? _____
Do you clench your teeth? _____
Are your teeth sensitive? _____
Are you interested in teeth whitening? _____
Are you on blood thinners? _____

Do you have any artificial joints or stints? _____
Do you have headaches/ migraines? _____
Have you had orthodontics? _____
Have you been diagnosed with sleep apnea? _____
Do you smoke or use tobacco? _____
Have you ever had a reaction to anesthetics? _____

Due to osteoporosis or cancer, are you taking or have taken Oral Bisphosphonate, e.g., **FOSAMAX, ACTONEL, BONIVA, RECLAST** or **IV Bisphosphonate**, e.g.; **ZOMETA, AREDIA, etc.?** If yes, how long? _____

List any medications you are allergic to: _____

List any medications you are taking or provide a copy of the list of medications: _____

_____

Patients Signature _____ Doctors Signature _____

Gateway Dental

Dr. Patricia Calabria DDS & Dr. Andre Ellis DDS

Welcome and thank you for choosing Gateway Dental for your dental health concerns. We are committed to providing you with the highest quality dental care in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding at the time of your visit.

Initial

____ You are responsible for knowing your benefit coverage for your visits.We gladly file your insurance claim on your behalf. We will not become involved in disputes between you and your insurance company regarding coverage, and or policy benefit criteria, i.e., deductible, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges, etc.

____ You are responsible for deductible, co-insurance, non-covered services, and any other charges your insurance may not cover. You will be sent statements on a monthly basis regarding any monies owed by you, the patient.

____ **Check-In:** Please arrive for your appointment a few minutes early, so that all paperwork may be completed before you see the dentist. Please bring your current insurance card with you to each visit.

____ **Check-Out:** Please be prepared to pay for the current visit as well as any past balances on your account. Payment of copays, deductibles, supplies or any non-covered services will be required at the time of service. Estimated patient responsibilities for all procedures will be determined by insurance estimates. We accept Cash, Check, Mastercard, Visa, Discover, and American Express.

____ **Late Arrivals:** If you arrive more than 5 minutes past your appointment time, you may be rescheduled so that other patients are not inconvenienced.

____ **Cancellations:** We require a 24 hour notice if you must cancel or reschedule your appointment. If you cancel the same day as your appointment, this may be considered a missed appointment. We reserved the right to charge a $60.00 fee for no show/late cancellations.

____ **No-Call/ No-Show:** 2 no-call/no-show appointments will be grounds for dismissal from the practice. Upon your request and written authorization, we will release all x-rays and/or records to the doctor of your choice.

____ **The cancellation and no-show fee are the sole responsibility of the patient and must be paid in full before the patient's next appointment.**

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Name:_____ Date of Birth:_____

Signature_____ Phone Number:_____

Authorization to Disclose Protected Health Information

Name: _____ DOB: _____

Address: _____ City _____ ST: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

I Authorize the Following to Disclose the Individual's Health Information

Gateway Dental
4013 Gateway Dr.
Colleyville, TX 76034
Phone: (817) 858-6333 Fax: (817) 868-0068

Who Can Receive and use health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Effective Time Period: This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date: _____

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person named under "Who can receive and use health information" I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature of Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by my Texas Health & Safety Code. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date: _____