

Valleydale Dental Associates
Gentry Gonzalez, D.M.D.
2633 Valleydale Road Suite 250
Birmingham, Alabama 35244
205-991-7797

Please Print

Patient Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Date of Birth _____ Social Security Number _____ Drivers Lic.# _____

How did you hear about our office? ___ Valpak ___ Billboard ___ Galleria Ad ___ Phone Book

___ Internet/Website ___ Insurance ___ Patient Referral (Patient Name) _____

Place of Employment _____ Emergency Contact _____ Phone# _____

****If you would like to be reminded of future appointment via email please give us your email address below:*

DENTAL INSURANCE INFORMATION

Our office will file your PRIMARY claim with most dental insurance carriers to assist you in receiving your benefits. However, we will make no guarantee of any estimated coverage. Due to the coordination of benefits with most carriers, WE DO NOT FILE TO SECONDARY. Because your insurance policy is an agreement between you and your insurance company, all patient are directly responsible for all charges. **CO-PAYMENT and/or YOUR ESTIMATED PORTION OF ANY CHARGE IS DUE ON THE SAME DAY OF SERVICE.** If for any reason your insurance has not paid your claim within 60 days from the date of service, you are responsible for full payment at that time. In this event, once payment is received in our office, we will assist you in receiving reimbursement from your insurance company. **INITIAL** _____

*Primary Dental Insurance Company _____ Group # _____

Contract ID Number _____

Who is the Policyholder _____ Policyholder Employer _____

Policyholder Birth Date _____ Policyholder Social Security# _____

Appointment Policy

We ask that you give a 24 hour notice if you need to cancel or change your appointment. If this becomes a consistent problem we will have to charge your account a missed appointment fee since we staff our office accordingly.

Medical History

When was your last PHYSICAL examination? _____ Reason _____

Has your physician ever told you:

You have a heart murmur? Yes No

You are a free bleeder? Yes No

You have Mitral Valve Prolapse? Yes No

You should take antibiotics before dental treatment? Yes No

Circle any of the following in which you have had:

High Blood Pressure Asthma Shortness of Breath Diabetes Tuberculosis

Anemia Heart Trouble Hepatitis HIV+

What medications are you taking now? _____

What medications are you allergic to? _____

Is there anything else we should know about your health? _____

Woman-Are you pregnant? _____ Scheduled due date? _____

HIPPA ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices and I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as set out in the Notice.

***Purpose of Consent**

By signing this form, you will consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set out in the attached "Notice of Privacy" and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

***Right to Revoke**

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed in our Notice of Privacy Practices. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating if you revoke this consent.

I, _____, Date of birth _____, have had full opportunity to read and consider the contents of t
(Print Patient Name)

this consent form and your notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as set out in notice.

Date Signed: _____

(Patient Signature)

*If signed by parent, guardian, or personal representative on behalf of the patient, complete the following:

Parent, Guardian, or Representative Name

Relationship to Patient

Date Signed

CONSENT FOR TREATMENT: I hereby consent to treatment to be preformed by Dr. Gonzalez and his associates. Furthermore, I understand the possible complications that might occur from a proposed treatment and that a perfect result cannot be guaranteed. If it becomes necessary to turn this account over for collections, I agree to pay all attorney's fees, court costs, and all other costs of collection of my account. The undersigned agrees to pay for all services rendered. This form was signed in Shelby County and all services are performed in Shelby County.

By signing this form, I understand that I am responsible for any balance on this account including any balance not covered or paid by my insurance provider.

Person Responsible For this Account: **Signature** _____ Date _____
(Parent or Guardian if Patient is a Minor)

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Consent for Use and Disclosure of Health Information, but we could not obtain because:

___ Individual Refused to Sign ___ Communication barriers prohibited obtaining the acknowledgement and consent

___ An emergency situation prevented us from obtaining acknowledgement and consent

___ Other: _____

Employees Initials _____

Verify Insurance Coverage

Deductible _____ Family Deductible _____ Does it apply to Prev. and Diag.? _____ Has deductible been met? _____

Year Dollar Maximum _____ Amount Used to Date _____ Contract Year _____

% That Insurance Covers

Preventative(1110) _____ %

How often are cleanings allowed? _____

Diagnostic(0330) _____ %

How often is a panorex allowed? _____

Basic(2140) _____ %

Endo(3310) _____ %

Perio(4341) _____ %

Major(2752) _____ %

Prosthetic(6242) _____ %

The following procedures to be entered in the message screen of employer:

Waiting Periods _____ Replacement Waits _____

Fluoride(1203) _____ %Limitations _____

Missing tooth clause _____

Sealants(1351) _____ %Limitations _____