CAVALIER DENTAL
Joseph Gondoly D.D.S., P.C.
PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING INFORMATION **1**

*IF THIS APPOINTMENT IS FOR YOU; SEE BELOW FOR **CHILD***

DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE		CELL PHONE	
SPOUSE CELL		WORK PHONE	EXT
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			
OCCUPATION			
EMPLOYER			
HOW WERE YOU REFERRED TO OUR OFFICE?			
PERSON TO THANK FOR YOUR REFERRAL			
EMAIL			

Minor/Dependant CHILD

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NUMBER			
BIRTHDATE	AGE	MALE	FEMALE

ACCOUNT INFORMATION **3**

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME			
RELATIONSHIP TO PATIENT			
*In the future, if we were to use an automated confirming service OR Text Message **CONFIRMATION** for your appointments.			
WOULD YOU BE INTERESTED IN THESE SERVICES? YES NO (circle one)			
IF YES, WHICH SERVICES? TEXT EMAIL (circle one)			
PHONE NUMBER TO TEXT:			

DENTAL INSURANCE **2**

PRIMARY CARRIER

INSURANCE COMPANY			
EMPLOYEE			
EMP. DATE OF BIRTH			
GROUP NUMBER			
UNION OR LOCAL NUMBER			
DATE EMPLOYED			
EMP. SOCIAL SECURITY NUMBER			

SECONDARY CARRIER

INSURANCE COMPANY			
EMPLOYEE			
EMP. DATE OF BIRTH			
GROUP NUMBER			
UNION OR LOCAL NUMBER			
DATE EMPLOYED			
EMP. SOCIAL SECURITY NUMBER			

IN CASE OF EMERGENCY **4**

PERSON TO CONTACT

NAME			
RELATIONSHIP			
PHONE NUMBER			
ADDRESS			
CITY		STATE	ZIP
BUSINESS PHONE			EXT.

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

PATIENT'S OR GUARDIAN'S SIGNATURE

_____ Date _____

SOME EXPECTATIONS WE HAVE OF YOU:

1) We expect that you will keep your appointments and be on time, and we will strive to be on time for you.

2) It is very important to complete your treatment and not stop half way through. Incomplete treatment could result in pain or loss of teeth.

3) Our office is committed to providing you with the best possible care, and would be happy to answer any questions concerning proposed treatment or financial arrangements for such. We deal with a large number of insurance carriers and programs, and we would be pleased to submit initial claims for you, with your assistance. Please remember, however, that:

A) not all services are covered benefits on all contracts. Some employers and programs arbitrarily select certain services they will not cover, regardless of the indication or need for such.

B) our fees generally fall within the range of what most major insurance carriers consider the usual and customary, and reasonable fees for this region.

C) your insurance coverage is a contract between you, the employer, and the insurance company; our office's relationship is with you, the patient. While the filing of insurance claims is a courtesy we readily extend to our patients, all charges and fees are the responsibility of the patient or responsible party from the date such services are rendered.

Unless other financial arrangements have been previously approved, patient payment is due at the time services are provided, and may be paid with cash, check, or major credit card. In cases where extensive treatment is needed, we would be happy to discuss and arrange different means of handling your account. We also realize that situations may arise which may affect timely payment of your account; if such should occur, we encourage you to contact us promptly for assistance in managing this situation.

If you should have any questions about the above information or uncertainty regarding insurance coverage, please don't hesitate to ask. Although the patient is responsible for insurance benefits and coverage information, we would be happy to help where we can. We are pleased to have the opportunity to work with you and provide the dental services you may need or request, while maintaining our consistently high level of quality and care.

I understand and agree that, regardless of insurance coverage, I am responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed it fully and correctly. I certify that this information is true, to the best of my knowledge, and will notify this office of any changes in my health status, insurance coverage, or any of the above information.

_____ _____

Signature (patient/parent/guardian) Date

Patient Privacy Information

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

Patient Acknowledgement and Consent

I consent to your disclosures of my information, which you deem necessary in connection with my treatment and billing. I understand that such disclosures may not be on the type listed above. I have also been given the opportunity to read the Notice of Privacy Practices.

_____ _____ _____

Patient Name (print) Patient Signature Date