The Office of Dr. Claudette Gibson

Patient's Name_____ Date of Birth:_____
(Last) (First) (M.I.)

Address_____ Age_____
(Street) (City) (State) (Zip)

Social Security #_____ Employer Name _____

Home Phone: (__)____-_____ Cell Phone: (__)_____-_____ Work Phone: (__)____-_____

Email Address:_____ Marital Status:_____ Gender:_____

In Case of an Emergency Please Call: _____
(Name) (Phone Number)

Reason for Visit:_____

How Long Have You Had This Condition:_____ Are You In Any Pain or Discomfort: _____

Age of Existing Dental Work (Bridge, Dentures, Partials):_____

Would you like whiter teeth or cosmetic dental procedures to improve your smile?_____

Any other concerns? _____

How did you hear about our office? _____

Primary Dental Insured or Person Financially Responsible

Name:_____ Social Security #:_____

Address:_____Birthdate:_____Age:_____

Home Phone: (__)____-_____ Cell Phone: (__)_____-_____ Employer Name/Phone_____

Insurance Co.:_____ Ins. ID#_____ Group ID#_____

Secondary Dental Insured Name:_____ SS#:_____

Address:_____ Birthdate:_____ Age:_____

Home Phone: (__)____-_____ Cell Phone: (__)_____-_____ Employer Name/Phone_____

Insurance Co.:_____ Ins. ID#_____ Group ID#_____

If Worker's Comp: Date of Injury:_____ Contact Name/Phone#:_____

Carrier's Name/Address: _____ Claim#:_____

If Auto Accident: Driver's Name:_____ Date of Accident:_____

Carrier's Name/Address: _____ Policy#:_____

If you have an attorney, please list their name/address/phone: _____

Are you allergic to any medicine, serum or food? If yes, Please list below.

_____

_____

Do you take any medications regularly? If yes, please list below. (aspirin, etc. included)

_____

_____

Have you had any operations? Please list type and date(s) below

_____

_____

Have you had any serious illnesses/injuries? Please list nature and dates below

_____

_____

Have you had local anesthesia for dental work or minor surgery?_____ Any reaction?_____

Do you smoke?_____ How much?_____ Do you drink alcohol?_____ How much? _____

Do you use recreational drugs?_____ If yes, what kind, and how often? _____

Have you been exposed to, or do you have any infectious disease such as hepatitis or AIDS? ___

Please Answer the Following Questions

Have you had, or do you have….

Yes	No	Birth defects, Trauma, or Infectious Disease (such as hepatitis, AIDS)
Yes	No	Eye, Ear, Nose, or Throat Trouble
Yes	No	Allergies or Asthma: Shortness of Breath or Chronic Cough
Yes	No	Chest pain, high or low blood pressure, excessive bleeding after injury or tooth extraction, Rheumatic fever, prosthetic heart valve, heart murmurs, mitral valve prolapse
Yes	No	Broken bones; amputated arm, leg, finger or toe; back trouble, rheumatism, arthritis, joint replacement

Yes	No	Stomach or intestinal problems, hepatitis or jaundice, kidney or bladder troubles, recent weight gain or loss
Yes	No	Headaches, dizziness, fainting, paralysis, seizures, head injury, nervous trouble
Yes	No	Skin disease, growth, tumor, cyst or cancer

Has any member of your family ever had?

Heart Disease Tuberculosis Diabetes Stroke Cancer Birth Defects

Other: _____

To the best of my knowledge, I have answered every question completely an accurately. I will inform Dr. Gibson of any changes in my health and/or medication(s).

Date:_____ Patient or Guardian's Signature:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Claudette Gibson DDS to furnish information to insurance carriers and/or my attorney concerning my illness and treatments; and I hereby assign insurance benefits payable directly to the doctors and understand that I am responsible for any non-covered expenses or attorney's fees incurred as a result of efforts to collect the bill. The assignment is irrevocable.

Date:_____ Patient or Guardian's Signature:_____

I also authorize the doctor to use photographs, x-ray's or casts for medical/scientific publication or exhibit.

Date:_____ Patient or Guardian's Signature:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ Please ***print*** name of Patient

_____ Please ***sign*** for Patient / Guardian of Patient

_____ Legal Representative / Guardian

_____ Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ____
- I could not communicate with the patient ____
- The patient refused to sign ____
- The patient was unable to sign because ____
- Other (please describe) ____

_____
Signature of Privacy Officer