Gulf Coast Oral & Facial Surgery

PATIENT INFORMATION:

Have you ever been a patient of our practice? ❑ Yes ❑ No
Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr._____
First Name M.I. Last Name

Sex: ❑ Male ❑ Female _____
Date of Birth Age Social Security # Drivers Lic. #

_____
Street Address Apt. # City State Zip

(_____)_____(_____)_____
Home Cell Email

_____(____)_____
Employer Bus. Tel.

_____
Referring Dentist Name Referring Orthodontist Name

_____(_____)_____
Name of Emergency Contact Phone Relationship

Student: ❑ Full Time ❑ Part Time ❑No _____
Name of School Address

GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

❑Self (If Self, Skip this section)

REFUNDS WILL ONLY BE ISSUED TO PERSON LISTED AS RESPONSIBLE PARTY.

Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the appointment will be listed as the guarantor.

_____
Last Name First Name

_____(_____)_____
Date of Birth Social Security # Phone

_____
Address of Guarantor Employer

_____
City State Zip Relationship to Patient

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

AUTHORIZATION TO MAIL, CALL OR EMAIL:
I certify that I understand the privacy risks of mail, phone calls, and e-mail. I hereby authorize a Gulf Coast Oral & Facial representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Gulf Coast Oral & Facial to that effect in writing.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read a copy of the Gulf Coast Oral & Facial Patient Information Privacy Policy. I hereby authorize Gulf Coast Oral & Facial or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I acknowledge full responsibility for the payment of all services and agree that I will take responsibility for all costs incurred by my failure to remit for services rendered.

I have read and understand **HIPAA Compliance**. **INITIAL_____** **Signed_____**
A copy will be given to patient upon request. Patient, Parent or Responsible Party

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by Gulf Coast Oral & Facial Surgery.

PATIENT / GUARANTOR SIGNATURE:_____DATE:_____