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 #_____

Please Circle your Cell Service Provider AT&T Verizon T-Mobile Sprint Virgin-Mobile Other_____

Date of Birth_____ Social Security Number_____ Drivers Lic.#_____

How did you hear about our office? ___ Google Search _____Phone Book ____Clipper Magazine

____Internet/Website ____Insurance ____Patient Referral (Patient Name) _____

Place of Employment_____ Emergency Contact_____ Phone#_____

*Email Address*_____

DENTAL INSURANCE INFORMATION

We are in network providers for the following PPO Plans- BCBS-AL, MetLife, Southland, Aetna, Cigna, Guardian, Delta Dental, and United Concordia. We are also in network providers for the Delta Dental Premiere plan. It is the patients responsibility to confirm that you are covered on your service date. 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.** Post dated checks are no longer accepted. 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 up to 40% of the balance due on 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)