Gateway Family Dentistry
Dr. Timothy Gailey
805 E Warner Rd, Ste 100
Chandler, AZ 85225

Medical Alert For Office Use

Thank you for visiting Gateway Family Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home (___) _____ Social Security # _____

Work (___) _____

Mobile(___) _____ ❑ Male ❑ Female

Email Address: _____

Emergency: Name _____ Phone (___) _____

Insurance

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone (___) _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

_____

Have your teeth ever embarrassed you in the last year? _____

Do you love your smile? _____

Is there anything you would like to change? _____

How long has it been since your last trip to the dentist? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

What did you like *least* about your last dentist? _____

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer- Chemotherapy
- ❑ Congenital Heart Disease
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ HIV Positive/ AIDS
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Sexually Transmitted Disease
- ❑ Yellow Jaundice
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain: _____

_____

List Medications currently taking: _____

_____

Female Patients: Are you pregnant?

❑ Yes ❑ No

If yes, when is your due date? _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

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480-857-0745

Thank you, for choosing our office for your dental needs. We are committed to your treatment being successful and are always available to answer your questions or assist you in any way we can. The follow is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **All patients** must complete all forms prior to being seen by the doctor
- All treatment estimates are valid for 90 days
- **Full payment** is due at the time of service. We accept Visa, Master Card, Discover, American Express and debit cards
- A $35 charge is incurred for returned checks
- Any balance left unpaid after 90 days will be turned over to small claims or collections and the patient will be dismissed from the practice

Regarding Insurance We accept assignment of insurance benefits. The balance is YOUR RESPONSIBILITY whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that the estimates that are given are just that. We do not guarantee insurance coverage or benefits. Please be aware that some or all of the services provided may not be a covered service under your insurance plan. **It is your responsibility to find out what is and is not covered.** You will be responsible for any balance not paid by your insurance company.

Minors The adult accompanying a minor to his/her appointment is responsible for payment at the time of service. Minors will not be treated if unaccompanied.

Missed Appointments Unless cancelled at least **24 hours in advance**, our policy is to charge for missed appointments at the rate of $35 per half hour. This will help us cover a portion of our costs to make up for the time **especially reserved for you**. Please help us serve you better by keeping your scheduled appointments! Excessive missed or cancelled appointments will result in dismissal from the practice.

Thank you for understanding our Office Policy. Please feel free to let us know if you have any questions or concerns.

I have read, understand and agree to the above financial policy.

Patient or responsible party _____

Date _____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $.25 for each page, $25.00 per X-RAY and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last 6 years but not before September 20, 2004. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions. But if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation as to how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances

Gateway Family Dentistry

Timothy Gailey, DMD
805 E Warner Rd., Ste 100
Chandler, AZ 85225
Phone: 480-857-0745
Fax 480-917-8955

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/20/2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use/disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may notify us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. Their contact information is provided for you at the end of this notice, as well.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C, 20201

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment

We may use and disclose your health information to a physician or other health care provider providing treatment to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations

We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Your Authorization

In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends

We must disclose your health information to you as described in the Patient Rights section I of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care but only if you agree that we may do so.

Persons Involved In Care

We may use or disclose health information to notify or in the assisting of notifying (including identifying or locating) a family member, your personal representative, or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health Related Services

We will not use your health information for marketing communications without your written authorization.

Required By Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
Dr. Timothy Gailey
805 E. Warner Rd. #100
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I understand that under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your **Notice of Privacy** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy from time to time and that I may contact this organization any time at the address above to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient_____

Signature:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy, but was unable to do so as documented below:

Date	Initials	Reason