

PATIENT HISTORY

Date: _____

Patient's name: _____ Date of Birth _____ S.S. # _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Place of Employment: _____

Spouse's Name: _____ Work Phone: _____ Place of Employment: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you to our office:

Person Responsible for this account:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION- Please read the following carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This consent allows disclosure to other physicians or healthcare providers to which you have been referred. _____ **INITIAL**

The purpose of Consent includes permission to release photographs, slides, or other diagnostic information for laboratory use, promotional purposes, study groups, lectures, testimonials, or Dr. Basil's website.

The undersigned completely and forever releases any right to present to future compensation in connection with the use of said materials, photographs and testimonials. _____ **INITIAL**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, 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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: The Basil Center for Complete Dental Care - John A. Basil, DDS
1703 Commerce Street, Wellsburg, WV 26070
Phone: 304-737-3050 Fax: 304-737-3051

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 above. 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 you if you revoke this Consent.

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.

Signature: _____ Date: _____

I give consent for my protected health information to be disclosed to: _____

CONSENT / APPOINTMENTS / PAYMENT / INSURANCE INFORMATION

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/ Child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child/minor named above, including but not limited to x-rays, application of fluoride, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

Signature: _____ Date: _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, utilities, etc., which still must be maintained whether you are present or not. Please remember that this time has been reserved for you, once the appointment has been made.

PAYMENT: Payment for dental services rendered is due at the time of treatment or as mutually agreed. I hereby authorize Dr. John A. Basil to charge my Visa/MasterCard/Discover account for any balance that is 90 days or more past due from the date the services were rendered.

Card # _____ Type of card: _____ Expiration Date: _____

Print Name of cardholder _____ Signature: _____ Date: _____

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

PRIMARY INSURANCE

Employee Name: _____ Relationship to insured: _____

Employee's Date of Birth: _____ Employee's S.S. #: _____

Primary Carrier: _____ Claim Mailing Address: _____

Insurance Phone #: _____ Group #: _____

SECONDARY INSURANCE

Employee Name: _____ Relationship to insured: _____

Employee's Date of Birth: _____ Employee's S.S. #: _____

Primary Carrier: _____ Claim Mailing Address: _____

Insurance Phone #: _____ Group #: _____

INSURANCE: We are happy to assist you obtain the maximum benefit from your insurance company.

INSURANCE & ASSIGNMENT OF BENEFITS

I authorize the release of any information relating to all of my claims. To avoid any misunderstanding regarding dental insurance, I understand that I am responsible for all costs of dental treatment whether insurance pays or does not. I also understand that all balances must be paid when services are rendered and any unpaid amount the insurance does not pay is my responsibility and must be paid immediately.

Signature: _____ Date: _____

Patient or Parent if minor/child

I hereby authorize payment of the dental benefits directly to John A. Basil, DDS. Also, I understand that if an insurance company sends the check directly to me or the subscriber listed above, it must be sent directly to Dr. John Basil, IMMEDIATELY, for payment of services, otherwise it will be turned over to the magistrate for collection.

Signature: _____ Date: _____

Patient or Parent if minor/child