



Robert W. Gardner DDS
CLINTONVILLE GENERAL DENTISTRY

Patient Registration

_____ ID

_____ Chart ID

_____ First Name

_____ Last Name

_____ Middle Initial

_____ Preferred Name

Patient is (circle one): Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

_____ First Name

_____ Last Name

_____ Middle Initial

_____ Address

_____ City, State, Zip

_____ Home Phone

_____ Work Phone, Ext

_____ Cell phone

_____ Birth Date

_____ Social Security Number

_____ Drivers License Number

Responsible Party is (circle one): Also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information:

_____ Address

_____ City, State, Zip

_____ Home Phone

_____ Work Phone, Ext

_____ Cell Phone

Sex (circle one): M F

_____ Birth Date Age

Marital Status: Married Single Divorced Separated Widowed

_____ Social Security Number

_____ Drivers License Number

_____ E-mail

Yes, I would like to receive correspondences via e-mail

Employment Status (circle one): Full Time Part Time Retired

Student Status (circle one): Full Time Part Time

_____ Medicaid ID

_____ Employer ID

_____ Carrier ED

_____ Pref. Dentist

_____ Pref Pharmacy

_____ Pref. Hyg

_____ Any Additional Comments:

Primary Insurance Information:

I hereby authorize assignment of my insurance initial rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____ Name of Insured

Relationship to Insured (circle one): Self Spouse Child Other Insured Social Security Number

_____ Insured Birth Date

_____ Employer

_____ Address

_____ City, State, Zip

_____ Insurance Company

_____ Address

_____ City, State, Zip

_____ Remaining Benefits

_____ Remaining Deductible



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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

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 healthcare 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name

Signature

Relationship to Patient

Date



Robert W. Gardner DDS
CLINTONVILLE GENERAL DENTISTRY

Dear valued patients,

Our staff of health care providers at Dr. Robert Gardner, D.D.S. is committed to maintaining the privacy we believe our patients deserve. Recent federal legislature mandates that health care providers comply with the Health Insurance Portability & Accountability Act of 1996, referred to as "HIPAA". Our office already complies with most aspects of HIPAA; however, we do need a family permission slip to continue our notification practices. Please be aware, we are not changing the way we notify you, we are merely asking that you acknowledge our existing office policy. Below you will find a list of our notification practices. Please take time to read them before you sign.

Permission for the following:

- **Submit your insurance claims electronically**
- **Leave a message on your voicemail or machine regarding appointments**
- **Leave a verbal message with another family member regarding your appointment**
- **Contact your insurance company, if warranted**
- **Mail a reminder postcard through the USPS**
- **Treat your minor children & discuss treatment with parents and or guardians**
- **Allow interoffice communication concerning your dental care**
- **Allow staff to discuss pertinent treatment with referring Doctors**
- **Discuss your case, by name, with our dental labs via telephone or mail to ensure accuracy and quality of work**
- **Other times your name might be used in the day to day normal operations of a dental practice**

We hope you understand that we are trying to comply with Federal Government regulations. In the future, the practices may change. If so our office will notify you.

Very truly yours,
Dr. Robert Gardner, D.D.S.

Dr. Robert Gardner, D.D.S. will not use any of our protected health information (PHI), including names, social security number, phone number, or financial information, in any way that is not connected with the proper dental treatment of your family.

You will be signing below agreeing that you have read and understand the HIPAA notification policy. My signature grants permission for Dr. Robert Gardner, D.D.S. to do the best of their reasonable ability to treat your family and understand your right to privacy.

Patient signature

Date