Jorge A Guel DDS
city base dental care

3138 S.E. Military Drive, Suite 104
San Antonio, TX 78223
(210)533-1100 office www.citybasedentalcare.com (210)333-3363 fax

# Patient Registration History Form

**How did you hear about our office?**

**_ existing patient _____**

**(Name of family member/friend/co-worker)**

**_ website/internet _ insurance _ word of mouth _ other: _____**

**Patient First Name:_____**
**Patient Last Name:_____ Initial:_____**
**Patient Preferred Name:_____**
**Street Address:_____**
**City:_____ State:_____ Zip:_____**
**Work Phone:_____ Extension:_____**
**Home Phone:_____ Cell Phone:_____**
**Sex: Male or Female**
**Marital Status: Married Single Divorced Separated Widowed**
**Birth Date:_____ Social Security #:_____**
**Driver's License #:_____**
**E-Mail:_____**
**Spouse's Name:_____**
**Spouse's Cell Phone:_____**

**In Case of Emergency, whom do we notify?**

**Name:_____**
**Phone:_____**

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# Patient Consent Form HIPPA Authorization

**PATIENT NAME** (please print)**: _____**

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 management analysis.

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* when deemed necessary and that I may contact this organization at the address above 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 execute 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.

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

I have read this form and agree to the uses and disclosures of the information as described.

**Date: _____ Patient Signature: _____**

If you are signing as a personal representative of the patient, please fill out information below.

**Date: _____ Relationship to Patient: _____**
**Print Name of Representative: _____**

**Print Name of Patient: _____**

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# CONCERNING DENTAL INSURANCE

## Name of Patient: _____

## Name of Dental Insurance: _____

## _____ I do not have dental insurance benefits. Please sign below.

As a courtesy, we will have a staff person to assist you in attempting to verify your dental insurance coverage. There is no guarantee of insurance coverage or payment. You should be aware that your dental insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided.

**WE WILL CHECK YOUR INSURANCE PRIOR TO COMING TO OUR OFFICE FOR THE FIRST TIME, AFTER THAT, ANY TIME YOUR INSURANCE CHANGES OR TERMINATES IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES. WE WILL BE HAPPY TO VERIFY YOUR NEW BENEFITS AND UPDATE YOUR RECORDS.**

I authorize and request my insurance company to pay directly to Dr. Jorge Guel, unless otherwise payable to me. I understand that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or pay less than the actual bill of services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by Dr. Jorge A Guel or the hygienists of City Base Dental Care. You agree to be responsible for payment in full for charges, including “Covered Services'' denied coverage by your insurance.

_____ _____

Signature of Patient or Guardian Date

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# APPOINTMENT CANCELLATION/LATE ARRIVAL/NO SHOW POLICY

**PATIENT NAME** (please print)**: _____**

**We require 48 hours' notice to make any changes to your appointment. If an appointment is not canceled at least 2 business days in advance or more, you may be charged a fifty-dollar ($50.00) fee.**

In order to provide the highest level of care to our patients, we have established an Appointment Cancellation/Late Arrival/No Show Policy that allows us to schedule appointments for all patients.

When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. This prevents you or another patient from getting much needed treatment.

**Our policy is as follows:**

**We require that you give our office 48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00 will be charged to you**; this fee cannot be billed to your insurance company and will be your direct responsibility.

No future appointments can be scheduled nor can records be transferred without the payment of this fee. Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms.

I also understand and agree that such terms may be amended from time-to-time by the practice.

**SIGNATURE OF PATIENT: _____ DATE: _____**