Liberty Hill Dental, P.A.

Thad H. Gillespie, D.D.S.

Date: ____________

PATIENT INFORMATION

Last: ______________________ First: ______________________MI___ Preferred Name: ________

Address: ______________________________ City: __________________ State: _____ Zip: _______

Home Phone: _______________ Cell: _________________ Email: ____________________

Social Security No: _____________________ Date of Birth: ________________ ☐ Male ☐ Female

Employer: ________________________ Occupation: _________________ Phone: _______________

Marital Status: ____________________ If Married, Spouses Name: ___________________________

PERSON RESPONSIBLE FOR ACCOUNT

Last: ______________________ First: ______________________ MI___ Relationship: __________

Address: ______________________________ City: __________________ State: _____ Zip: _______

Home Phone: ____________________ Cell: _________________ Email: _____________________

Social Security No: _____________________ Date of Birth: ________________ ☐ Male ☐ Female

Employer: ________________________ Occupation: _________________ Phone: _______________

Marital Status: ____________________ If Married, Spouses Name: ___________________________

INSURANCE INFORMATION

Do you have Dental Insurance?: ☐ Yes ☐ No *If yes, please give the front desk your insurance information*

HOW DID YOU HEAR / FIND LIBERTY HILL DENTAL?

(Please circle one: **Phone** **Website** **Friend/Family)**

Did you read any reviews online before deciding to make an appointment? If so what review? ___________________

Friend/Relative – if so, who? ______________________________ Sun Rays Magazine:_________

School Program: _____ Courage Cheer: _____ Driving by: ___ Phone book: ________ LHD Website: _______

Facebook: ____ Twitter: ______ Google +: ____ LinkedIn: ____ Pinterest: ____ You Tube: ___ Dental School: _______

Austin Spurs: _______ Chamber directory: _________ Lighthouse 360 review (Rate-A-Dentist); _____

Search engine (Google, Yahoo, Bing): _________________ Other (please explain): _____________________

HOW WOULD YOU PREFER TO BE CONTACTED (circle all that apply)? *Please provide this information above.

Email **Text** **Phone Call**

PAYMENT, TREATMENT AND CANCELLATION POLICY

PAYMENT POLICY:

Keeping your mouth healthy means keeping you healthy! It is our goal to provide the best possible dental care for you and your family. We want to do everything we possibly can to make the best possible dental care both pain-free and affordable. Please ask one of our administrative staff for information regarding payment options if you are interested.

Payment is due at the time of service. There is cash or check discount for total fees over $250.

As a courtesy for those with insurance, we will accept assignment of your insurance; though, your estimated portion is due at the time of the service. The balance or any portion not paid by the insurance company within 60 days is your immediate responsibility. Liberty Hill Dental, P.A. is considered out of network and there are instances when your insurance company will pay the subscriber (the patient) for the services provided to you in this office, if that happens, it will be the responsibility of the patient to pay the total amount of the bill in full, we will file the insurance claim for you and your insurance company will pay you for the services rendered (unless previous arrangements are made).

IF YOU HAVE INSURANCE:

- All fees are your responsibility regardless of insurance payment
- You are responsible for providing current insurance information
- Estimated portions are due at the time of service
- Balance not paid by insurance within 60 days is your immediate responsibility

Please initial the following if you have insurance:

______ ***I UNDERSTAND THAT* Liberty Hill Dental, P.A. is filing my insurance claim(s) on my behalf and that I am financially responsible for any amount that my insurance company does not pay.**

______ ***I UNDERSTAND THAT* Liberty Hill Dental, P.A. is *OUT OF NETWORK* for *ALL* insurance carriers.**

______ I hereby authorize the release of information of my dental records to my insurance company.

______ I hereby authorize direct reimbursement to Thad H. Gillespie, D.D.S. & Liberty Hill Dental, P.A.

TREATMENT POLICY *(please initial the following):*

______ I hereby authorize Dr. Thad H. Gillespie and the staff of Liberty Hill Dental, P.A. to perform the treatment necessary to maintain my dental health and hygiene.

CANCELLATION POLICY *(Please initial the following):*

______ I agree to provide 48 hours notice for any scheduling changes or cancellations to prevent fees from being assessed to my account.

I have read and understand the ***PAYMENT, TREATMENT AND CANCELLATION POLICY.***

______________________________ ______________________________

Patient or Guarantor Date Office Staff Date

Liberty Hill Dental, P.A.
Thad H. Gillespie, DDS
14933 West State Hwy 29
Liberty Hill, TX 78642
512-515-0171

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Statement of Privacy Practices for the office of Thad H. Gillespie, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Thad H. Gillespie, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practice at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you also give permission for our office to share your treatment information with approved dental providers and/or your insurance company either by electronic, written or verbal disclosure.

Pursuant to the Texas Administrative Code, Title 22, Part 9, Chapter 165, Rule §165.2: In the case you need to request your records from our office, Liberty Hill Dental, P.A is required to provide those to you within 15 business days of the requested date. Please submit your request in writing to our office at the above address. Applicable charges may be assessed.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorized disclosure of my protected health information to the persons indicated below:

		YES		NO
ANY MEMBER OF MY IMMEDIATE FAMILY				
SPOUSE ONLY				
OTHER (Please specify)				

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgment not obtained

PROVIDED PRIOR TO TREATMENT?		YES		NO	**If Yes, DATE:**
REASON FOR DENIAL:					
	Needed more time to review Statement of Privacy Practices				
	Wanted to consult with another person before signing				
	Unable to sign				
	Reason not given				
	Other (please explain):				

Liberty Hill Dental, P.A.

Children's Health / Dental History

Date: ___________

To be filled out by parent or guardian:

Child's Name: ____________________ Prefers to be called: _______________ Age: ______

Mother's Name: ________________________ Father's Name: ________________________

Physician's Name: ______________________________________ Phone: _______________

Please check the appropriate box (Yes or No):

1. Is your child currently being treated by a doctor? Yes No

If yes, please explain:____

2. Is your child currently taking any medications? Yes No

If yes, please explain:____

3. Has your child been hospitalized or been seriously ill? Yes No

If yes, please explain:____

4. Is your child allergic to any medications or drugs? Yes No

If yes, please explain:____

5. Are there any other medical conditions we should be aware of? Yes No

If yes, please explain:____

This portion to be filled out by your child

Have you seen a dentist before? Yes No When? ______________________________________

What was it like? ____

How do you feel about seeing us? ____

What do you know about coming to see us? ______________________________________

What do you know about taking care of teeth? ___________________________________

Do you think you take care of your teeth most of the time? Yes No

Younger children may prefer to draw a picture of the dentist office or of their mouth/teeth.