

DR. GUION GEE REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members seen here:							

SPOUSE OR RESPONSIBLE PARTY INFORMATION							
Patient's last name:		First:			Middle:		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status – Single/ Mar/ Div/ Sep / Wid		Birth date:		Social Security #		
Driver's License #		E-mail Address:					
Address:			City:		State:	Zip Code:	
Home Phone:			Work:		Ext:	Best time to call:	
FAX			PAGER			OTHER	

THE FOLLOWING IS FOR: THE PATIENT THE PERSON RESPONSIBLE FOR PAYMENT

EMPLOYER NAME:		ADDRESS:					
CITY:		STATE:		ZIP CODE:		PHONE:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Occupation:		Employer:		Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]		
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other				
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other				

Dental History		
PLEASE ANSWER THE FOLLOWING QUESTIONS		
Date of Last Dental Visit:		
Are you allergic to penicillin?	Yes	No
Do you have any other allergies? If yes, what?	Yes	No
Are you on any medication? If so, for what?	Yes	No
Does your Medical History Include Any of the Following		
Are you a diabetic?	Yes	No
Is there a history of diabetes in your family?	Yes	No
Do you have a lung condition?	Yes	No
Are you anemic?	Yes	No
Are you a hemophilac?	Yes	No
Have you ever tested positive to AIDS/HIV	Yes	No
Have you ever had hepatitis?	Yes	No
Have you ever had rheumatic fever?	Yes	No
Do you have frequent fever blisters or mouth ulcers?	Yes	No
Do you have a history of cancer?	Yes	No
Do you have any artificial valves of joints?	Yes	No
Do you have sinus problems?	Yes	No
Do you have high/low blood pressure?	Yes	No
Have you ever required a blood transfusion? If so, when?		
Abnormal heart condition? If yes, please explain		
Are there any other conditions we should be aware of?		
Who is your physician?		
List Drugs you are presently taking:		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Guion Gee. or insurance company to release any information required to process my claims.</p>			
<hr/> <i>Patient/Guardian signature</i>		<hr/> <i>Date</i>	

DR. GUION GEE

PATIENT AGREEMENT

1. I, the undersigned, consent to examination (physical, photographic and/or radiographic x-ray) of me or my charge by Dr. Guion Gee, for the purposes of diagnosis of any afflictions for which I may or may not have sought treatment. I understand the treatment recommendations may be made and discussed and it is my right and duty to decide whether or not to accept and follow those recommendations or alternative recommendations that may be made.
2. I warrant that any and all answers that I may give relating to identifications, insurance information, medical history and treatment follow-up shall be truthful to the best of my knowledge.
3. I understand that this is a fee-for-service practice and that unless there is prior agreement between me or my insurance carrier(s) and Dr. Gee or her designate, all fees are due and payable at the time of service. Our method of payment is cash, check or bank card. We accept payment from your insurance company, and you will be responsible for your estimated share on the day of service. Any remaining balance will be due within 60 days. I understand that a service fee of a minimum \$3.00 charge will be assessed on any past due account greater than 60 days. I agree to pay any reasonable cost incurred by Dr. Gee or his designate in attempting to collect past due accounts as are due from me, including legal fees and court costs. I understand that there will be a \$25.00j service charge for any returned non-sufficient fund checks.
4. I understand that my insurance policy(s) are agreements between me and the insurance company(s) and do not involve Dr. Gee. I understand that while Dr. Gee and his staff may assist me with filing insurance claims for service rendered, I am ultimately responsible for any and all fees due. I hereby give Dr. Gee permission to file on my behalf any insurance forms, to make any inquires or release any information that may be required to obtained benefits as are due me. I hereby give authority to any insurance company(s) representing me or my charge to make payments to Dr. Guion Gee on my behalf. I understand that should my insurance company(s) fail or refuse to pay, for whatever reason, for services rendered by Dr. Gee, I will continue to be liable for any balance due.

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature: _____

Responsible Party's Name: _____

Date: _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
Signature: _____	Signature: _____
Date: _____	Date: _____