GJ Smiles
Carl A. Feghali DDS, PC

REGISTRATION

WELCOME TO OUR OFFICE

The benefits of a happy, healthy smile are immeasurable. Our mission is to help you reach and maintain excellent oral health. Please fill out this form completely to allow us to serve you better.

1. CONFIDENTIAL PATIENT INFORMATION

Name (First,Middle Initial, Last) ☐ M ☐ F Birth Date SS #

Home Phone Cell. Phone **E-mail**

Residence Address (City, State, Zip)

Mailing Address (City, State, Zip)

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or Parent / Guardian's Employer (First,Middle Initial, Last) Work Phone

Occupation No. of Years Employed

Spouse's Name (First,Middle Initial, Last) Birth Date SS #

Employer Work Phone Occupation No. of Years Employed

Whom may we thank for referring you to our office?

2. CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for this Account (First,Middle Initial, Last) Relationship to Patient

Address (City, State, Zip) Home Phone Cell. Phone

How long at this address Landlord Phone

Previous Address - If less than 3 years (City, State, Zip)

Birth Date SS # Driver's License #

Employer Work Phone

Is this person currently a patient in our office? ☐ Yes ☐ No

3. INSURANCE INFORMATION

We offer to help you submit claims to your dental insurance company, but we cannot guarantee your benefits. Your insurance policy is a contract between you and your insurance company. WE cannot diagnose or recommend treatment based on insurance coverage or benefits. We recommend treatment to help our patients maintain optimum dental health. If your insurance company fails to provide benefits for treatment we have rendered, it is your responsibility to pay your balance in full. Please be advised that it is your responsibility to inform us of any changes to your coverage in order for us to make sure claims are submitted correctly.

Policy Holder's Name (First,Middle Initial, Last) SS or Member #

Insurance Company Group #

Birth Date Policy Holder's Employer

Do you have dual insurance coverage? ☐ Yes ☐ No If yes, please answer the following questions:

Policy Holder's Name (First,Middle Initial, Last) SS or Member #

Insurance Company Group #

Birth Date Policy Holder's Employer

4. EMERGENCY CONTACT INFORMATION

- Name ----------
  (First,Middle Initial, Last)

  Relationship to Patient ---------- Home Phone ---------- Cell. Phone ----------

  Address ----------
  (City, State, Zip)

- I authorize the dental staff to perform any necessary dental services I may need for diagnosis and treatment, the release to my insurance carrier any medical information requested, and request that payment of authorized insurance benefits be made on my behalf to Carl A. Feghali DDS, PC.
- I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine whether Insurance coverage is available or not, due and payable at the time services are rendered, unless financial arrangements have been made. I understand that where appropriate, credit bureau reports may be obtained. In the event of default (I/We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
- I hereby instruct and direct my Insurance Company to pay **Carl A. Feghali DDS, PC** or, if my current policy prohibits direct payment to doctor, please make out the check to us and mail it to **1120 Wellington Ave Suite 203 - Grand Junction, CO 81501** for the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize the Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the Patient.

Date Signature of Client or Responsible Party

5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ---------- have been given the option to review a copy of the G.J.Smiles of Privacy Practices.

This form is used to obtain your consent to communicate with you by email and mobile text messaging regarding your Protected Health Information. G.J.Smiles offers patients the opportunity to communicate by email and text for these purposes. G.J.Smiles will use reasonable means to protect the security and confidentiality of email and text information sent and received. However; G.J.Smiles cannot guarantee the security and confidentiality of email and text communication and will not be liable for inadvertent disclosure of confidential information.

Do we have permission to?

- Send appointment reminders and info to your home/text/email ☐ Yes ☐ No
- Leave appointment information ☐ Yes ☐ No
- Billing information ☐ Yes ☐ No
- Dental information ☐ Yes ☐ No

Please list family members we have permission to speak with regarding treatment and/or your family account:

Information to be disclosed: (Please check all that apply)

- Appointment dates & times ☐
- Treatment plans & referrals ☐
- Financial & billing information ☐
- Any other pertinent dental health information related to treatment at this office ☐

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and text between G.J.Smiles and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered. This permission will remain in effect unless a written cancellation has been provided.

Date Signature of Client or Responsible Party