Welcome to
Gil Rivera, DMD, PA

Patient Information

(Please complete the information below.
Your information will be considered Confidential)

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Name: _____ Birth Date: _____

Address: _____ City: _____ State/Prov. _____ Zip: _____

Social Security Number: _____ Driver's Lic. No. _____

Please circle acceptable ways to you to receive Appointment Reminders, Invoices and other mailings from the office:

Email Text Messages Cell Phone Postal Mail

Financial Institution: _____

Circle as Appropriate: Minor Married Single Widowed Divorced

Spouse, Parent or Guardian's name: _____ Employer _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Contact Phone: _____

Referred by? _____

Responsible Party (If different from Above)

Name: _____ Relationship To Patient: _____

Address: _____ Contact Phone: _____

*Email Address: _____ Consent to Receive Bills Via Email? YES NO (Please Circle)

SSN: _____ Driver's Lic. No: _____ Birth Date: _____

Financial Institution: _____ Employer: _____ Work Phone: _____

For your convenience, the following forms of payment are available to you. Please check your preferred option. Payment in full for services rendered is expected on the day of service.

☐ CASH ☐ Personal Check ☐ VISA ☐ MASTER CARD ☐ DISCOVER ☐ CARE CREDIT

Insurance Information

Name of Insured: _____ Relation to Patient: _____

Birth Date: _____ SSN: _____

Name of Employer: _____ Work Phone No. _____

Insurance Company: _____ Group No. _____ Policy ID No. _____

Insurance Company Address: _____ City _____ State: _____ Zip: _____

Patient Medical History

Primary Care Doctor: _____ Office Phone: _____

		YES	NO
1	Are you under medical treatment now?		
2	Have you been hospitalized for surgery or serious illness during the past 5 years? If "YES", please explain:		
3	Are you taking any medications? If "YES", please list:		
4	Any non-prescription medications? If "YES", please list:		
5	Do you currently use or have you ever used tobacco? If "YES", How much? For how long?		

		YES	NO
6	Do you use controlled substances?		
7	Are you allergic or have had any reactions to the following?		
	Local Anesthetics		
	Penicillin or other Antibiotics		
	Sulfa Drugs		
	Barbiturates		
	Sedatives		
	Iodine		
	Aspirin		
	Any Metals (nickel, mercury, etc.		
	Latex Rubber		
	Other (Please list)		

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure			AIDS / HIV Infection			Sexually Transmitted Disease		
Heart Attack			Thyroid Problem			Chest Pains		
Rheumatic Fever			Heart Disease			Stroke		
Fainting/Seizures			Cardiac Pacemaker			Tuberculosis		
Asthma			Heart Murmur			Radiation Therapy		
Low Blood Pressure			Anemia			Liver Disease		
Epilepsy/Convulsions			Emphysema			Heart Trouble		
Leukemia			Cancer			Respiratory Problems		
Diabetes			Joint Replacement / Implant			Mitral Valve Prolapsed		
Kidney Disease			Hepatitis / Jaundice			Other: _____		

Women Only

		Y	N
1	Are you pregnant or think you might be pregnant?		
2.	Are you nursing?		
3.	Are you taking oral contraceptives?		

Appointment Cancellation Policy

Drs. Rivera and Caranante schedule the day very carefully to see the patients at their appointed time. If you need to reschedule your appointment time, please provide us with hours notice. After the first cancellation or change of appointment, there will be a $25 cancellation fee applied to your account.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of Dental care, to third party payers and/or health practitioners. I authorize and request my Insurance Company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Patient Signature and Date

GIL RIVERA, DMD, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: _____

E-mail:_____

Patient #:_____Social Security #:_____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gil Rivera, DMD
Telephone: (813) 933-5331 **Fax:** (813) 932-5027
E-mail: glriveradmd@aol.com
Address: 4107 N Himes Ave - Ste 102 Tampa, FL 33607

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following: Personal Representative's Name:_____
Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____