Harrison W. Gollob, DMD
130 Interlachen Rd, Suite A
Melbourne, FL 32920
(321)255-4644

**Name:** _____ **DOB:** _____

**Address:** _____**City:**_____**State:**_____**Zip:**_____

**Billing Address if Different:** _____

**Sex:** _____ **Marital Status:** Married / Single / Widowed / Divorced

**Phone: Cell:**_____ **Home:**_____

**Social Security Number:** _____

**Email:** _____

**Is it ok to receive text reminders?** YES or NO
**Is it ok to receive email reminders?** YES or NO

**Is it ok to leave detailed messages?**

- On your voicemail: YES or NO
- With a third Party: YES or NO

**Name of Third Party** : _____**Relation**:_____

**If patient is a child parent/guarantor name/relation:** _____

**Emergency Contact** and Phone:_____

Name of Medical Doctor: _____

Phone Number: _____ Date of Last Visit to Medical Doctor:_____

Name of Previous Dentist: _____

Phone Number: _____ Date of Last Visit to Dentist _____

How were you recommended to our office?_____

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Name: _____Date: _____

**Primary Dental Insurance:**

Insured's Name: _____

Social Security Number: _____

Employer: _____

Member ID: _____

Group Number**:** _____

Insurance Company: _____

Address:_____

_____

Phone: _____

**Secondary Dental Insurance:**

Insured's Name: _____

Social Security Number: _____

Employer: _____

Member ID: _____

Group Number**:** _____

Insurance Company: _____

Address:_____

_____

Phone: _____

**FINANCIAL POLICY AND INSURANCE POLICY CONSENT**

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my insurance policy in regards to my eligibility and benefits including limitations and exclusions. I understand that filing of insurance claims is my responsibility and is provided by Dr. Gollob's office as a courtesy. I am also aware that any agreement for dental coverage is between my insurance company and me. It is the patient's responsibility to notify our office of any changes prior to services. Failure to do so may result in a denied claim and transfer of balance to patient responsibility.

**We are not contracted with any insurance companies and we do not agree to their fees**. We are a PPO non-restricted provider and will work with your insurance to limit any extra cost that could occur when working with an out of network provider**. You are expected to pay your percentage at the time of your visit.** We can either request a predetermination from your insurance and/or provide you an approximate estimate of what your insurance plan is expected to pay to an out of network PPO provider. **If the full estimate is not paid by your insurance company, the remaining portion becomes your responsibility**. Some insurance companies will mail their portion of the dental bill to the subscriber. We are still willing to work with you and your insurance company in this case, but may bill you for the full amount at the time of service. If you have a secondary insurance we can properly file a claim to the secondary insurance on your behalf.

**Signature**_____

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Name: _____Date: _____

## Office Policy

The office does not provide private financing. We require you to sign a consent form for most services to be performed other than routine dental care.

There may be times Dr. Gollob may take additional x-rays, images or models at no fee. It is at the doctor's discretion on whether these will be released to the patient should they leave the practice unless the usual fees for these services have been paid.

We are a high quality, low volume office which means we do not overbook. We do this so that we can provide you with the time for quality treatment. We call or text one to two days prior to your scheduled appointment to confirm that we have a convenient time to accommodate your schedule. Your time is valuable and so is ours. **We require notice at least 24 hours before your appointment if you need to make a change.**

Our office bills on a monthly basis. Payment is due at the time service is rendered. We estimate co-pays based on information we receive from your insurance company. If you require a more accurate figure we suggest that you request that we submit a pretreatment estimate to your insurance. Having a pretreatment estimate will help attain the most accurate information.

**Balances over 90 days may be assessed finance charges in the amount of 1.5% of the balance.**

## Authorization to Release Information

I hereby authorize Dr. Gollob to release information acquired in the course of my examination or treatment to my insurance company, or other providers required to participate in my care.

**Guarantee of Account**

I have read and understand the above information. I agree to the above office policies. I have had the opportunity to ask any and all questions regarding the office policies referenced above. All questions have been answered to my satisfaction.
This is to certify that the signature below promises to be responsible for any charges incurred on patient account. Patient balances will be due at the time of each visit.

**Patient/Guarantor Signature:_____Date:_____**

**Witness Signature:_____Date**:_____

Viera Dental Arts

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Name: _____Date: _____

## BROKEN APPOINTMENT OFFICE POLICY

Our office requests that when you make an appointment; please make every effort to keep your appointment as our office has specifically set this time aside for you. Any forms of appointment reminders are a courtesy we as an office provide. It is your responsibility be aware and keep your appointment. It is your responsibility to provide a 24 hour notice to cancel or reschedule any appointments. Should you cancel, reschedule or no-show an appointment without the 24 hour notice you may be charged a fee of $50. In addition, should you show up late to your appointment and we are unable to accommodate you, the same fee will be charged.

Excessive late arrivals, no shows or and/or cancellations may result in dismissal from our practice.

Thank you for your acknowledgement of our office policy

**Patient Name Printed**: _____**Date**: _____

**Patient Signature:** _____

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Name: _____ Date:_____

REVIEW OF SYMPTOMS:
The following are questions that will help Dr. Gollob better understand your current health status. Please read and answer carefully. Have you within the last twelve (12) months had any of the following?

You may add what you feel is missing.

| | | | |
|---|---|---|---|
| Fatigue | Yes or No | Sinus Trouble | Yes or No |
| Fever | Yes or No | Hoarseness | Yes or No |
| Weight Gain | Yes or No | Dry Mouth | Yes or No |
| Weight Loss | Yes or No | Abdominal Pain | Yes or No |
| Weakness | Yes or No | Constipation | Yes or No |
| Chest Pain | Yes or No | Diarrhea | Yes or No |
| Palpitations | Yes or No | Heartburn | Yes or No |
| Heart Murmur | Yes or No | Food intolerance | Yes or No |
| Heart Valve Problem | Yes or No | Nausea | Yes or No |
| Rheumatic Fever | Yes or No | Arthritis | Yes or No |
| High Blood Pressure | Yes or No | Stroke | Yes or No |
| Low Blood Pressure | Yes or No | Thyroid Problems | Yes or No |
| Pacemaker | Yes or No | Anemia | Yes or No |
| Shortness of Breath | Yes or No | Diabetes | Yes or No |
| Cough | Yes or No | Tuberculosis | Yes or No |
| Wheezing | Yes or No | Joint Replacement | Yes or No |
| Seizures | Yes or No | Intestinal Problems | Yes or No |
| Fainting | Yes or No | Hepatitis | Yes or No |
| Dizziness | Yes or No | Glaucoma | Yes or No |
| Easy Bruising | Yes or No | Abnormal Bleeding | Yes or No |
| Headaches | Yes or No | Asthma | Yes or No |
| Head Injury | Yes or No | Ulcers | Yes or No |
| Hearing Problems | Yes or No | Special Diet | Yes or No |
| Lightheadedness | Yes or No | Pre-Medication | Yes or No |
| Backache | Yes or No | Cancer | Yes or No |
| Neck pain | Yes or No | Tumor | Yes or No |
| Low back pain | Yes or No | Herpes or other STDs | Yes or No |
| Joint pain | Yes or No | HIV Positive/AIDS | Yes or No |
| Muscle pain | Yes or No | Blood Transfusion | Yes or No |
| Excessive thirst | Yes or No | Blood Problems | Yes or No |
| Swollen Glands | Yes or No | Other _____ | |

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Name:_____ Date:_____

History of alcoholism Yes or No
History of drug abuse Yes or No
Wear contact lenses Yes or No

During the past 12 months have you taken any of the following?

Antibiotics Yes or No
Anticoagulants Yes or No
High Blood Pressure Yes or No
Bisphosphonates Yes or No
Insulin Yes or No
Aspirin Yes or No
Digitalis Yes or No
Nitroglycerin Yes or No
Cortisone Yes or No
Natural Remedies Yes or No
Supplements Yes or No

Are you allergic or have you reacted adversely to any of the following?

Local Anesthetics Yes or No
Antibiotics Yes or No
Sulfa Drugs Yes or No
Aspirin Yes or No
Acetaminophen Yes or No
Ibuprofen Yes or No
Latex Yes or No
Codeine Yes or No
Narcotics Yes or No
Metals Yes or No
Other: _____
_____

What medications are you currently taking? Please list all prescription and OTC supplements:_____
_____
_____
_____
_____
_____

WOMEN ONLY
Are you taking contraceptives or other hormones?_____
_____

Are you pregnant?_____
If so, expected delivery date:_____

Have you reached menopause?_____
If so, do you have any symptoms?_____
_____

_____
**Patient Signature and Date**

_____
**Office Signature and Date**

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Name:_____ Date:_____

# Patient HIPPA Consent Form

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this _____day of _____20_____

Signature: _____

Relationship to Patient: _____