PATIENT INFORMATION

PATIENT

Name ______________________________
Last First
Address ____________________ Apt. # _____
City ____________________ Zip __________
Phone Mobile ______________________
Phone Home ______________________
Phone Work ______________________
E-mail ______________________
Social Security # ______________________
DL# or Govt. Issued ID______________________
Date of Birth _____/_____/________
Employer: ______________________

RESPONSIBLE PARTY (If same above, pls. skip)

Name ________________ Last________________
Address ______________________
Apt. # ________ City / Zip ____________/ ________
Phone (Mobile):______________________
Phone (Home):______________________
Phone (Work):______________________
E-mail : ______________________
Social Security # ______________________
DL or Govt. Issued ID# ______________________ _
Date of Birth ______________________ _
Relationship to Patient ______________________

PERSON TO CONTACT FOR EMERGENCY:
Name: ________________Last________________
Phone (Mobile) ______________________
Relationship to Patient ______________________
Physician ________________ Phone ______________

GETTING TO KNOW YOU

How did you hear about our office? (Check one)

☐ Insurance Plan ☐ Family-Friend ☐ Yellow Pages
☐ Family-Friend ☐ Newspaper ☐ Flyer-coupon
☐ Office Sign ☐ Direct Mail ☐ Website
☐ Facebook , Social Media

Please let us know, if anybody referred you to us:
Name: ______________________

INSURANCE / DENTAL PLAN

Primary Insurance: ☐ PPO ☐ HMO (Check one)
Plan Name ______________________
Address ______________________
City, Zip ______________________
Insurance I Plan Phone # ______________________
Employer ______________________
Group # ______________ Plan# ______________
Primary Insured's Name: ______________________
Primary Insured's Soc. Sec. # ______________________
Primary Insured Birthdate _______ _

INSURANCE / DENTAL PLAN

Secondary Insurance: ☐ PPO ☐ HMO (Check one)
Plan Name ______________________
Address ______________________
City, Zip ______________________
Insurance I Plan Phone # ______________________
Employer /Union /Local ______________________
Union/Local _______ Group # ________ Plan# ________
Insured's Name ______________________
Insured's Soc. Sec. # ______________
Date of Birth _____/____/______

I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me or an any additional applicants requiring reports from credit reporting agencies. I authorize payment directly to the dentist of any group insurance benefits therwise payable to me. I authorize release of any information relating to any dental claim or claims.
3. I understand that each dentist is individually responsible for dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

____
Signature of Patient or Guardian, if, Patient is minor

Date ______________________

Please complete both sides of this form

A. PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

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Print Patient's Name

____

Print Guardian' Name, if Patient is Minor

I, acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

B. PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES / EMAIL / TEXT MSG

I give permission to:
Send a recall appointment reminder to your home OR contact you or leave appointment, billing or dental information on your answering machine/Telephone / voice mail/e-mail /text

C. FINANCIAL POLICY

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following and sign/date the bottom of this form to accept Financial Policy.

- Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.
- Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.
- Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.
- Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.
- There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)
- Patient balances that go unpaid for 30 days or more may incur one or more of the following charges subject to state and federal regulation maximum: *Interest charges of 1.5 % per month or 18% APR, Collections fees (up to 42% of the full balance), Legal fees for collection services*

I, acknowledge that I read & accept

A. NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION
B. PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES / EMAIL / TEXT MSG
C. FINANCIAL POLICY

____________ ______________________________

Signature of Patient or Guardian if Minor

Date: _________________________