PATIENT INFORMATION

Patient Name: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Email: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Patient Address: _____
Street Apartment #

_____
City State Zip Code

GUARANTOR INFORMATION (if you are not policy holder under insurance)

Name: _____
Last, First

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Guarantor Address: _____
Street Apartment #

_____ _____
City State Zip Code

MISSED & CANCELED APPOINTMENT POLICY

Since appointment times are reserved exclusively for existing and potential patients, we ask that you please be on time for your appointments.

In order to best serve our patients, we request that you make any appointment changes or cancellations 48 hours in advance. This insures that you avoid being billed for our time and preparation.

We reserve the right to charge a missed appointment fee of up to $25.00 for each broken/ missed appointment. It is still considered a no show if we do not receive a courtesy call 48 hours prior to your appointment. If you receive (3) no shows, you are subject to being discharged.

We realize that unexpected things can happen, but we ask for your assistance in this regard. In addition, we may require future appointments to be paid in full for patients that consistently do not show for their appointments.

As a courtesy, our office will attempt to contact you by phone for confirmation 1-2 days before your scheduled appointment. However, we do ask that you assume responsibility for your appointment time.

I have read the Missed & Canceled Appointment Policy and agree to its content.

_____ _____
Signature of patient, parent, or guardian Date

OFFICE FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made prior to dental services. It's the patient's responsibility to inform the front desk of any changes to your dental insurance coverage before services are rendered.
All emergency dental services performed without previous financial arrangements must be paid in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he/ she is personally responsible for payment. This office will help prepare the patients dental insurance forms and assist in making collections from the dental insurance companies. Upon your request, our office will submit an estimate of dental treatment to your insurance. This estimate will provide an approximate copay that will be paid at or before the time of dental service.

For your convenience, we accept Cash, Visa, AMEX, MC, and Care Credit. In the event a check is returned to our office due to insufficient funds, the check will be returned to the patient and the patient will be charged a $15.00 fee that's due immediately.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for services at the time of treatment. I understand that the fee estimates for dental care can only be extended for a period of 6 months from the date of consultation.

*Until all insurance claims are paid, no refunds or credits will be issued.

PRE-PAYMENT POLICY

(Any treatment scheduled $500 + or more)

Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment, you are agreeing to take care of your dental needs.

Money that you prepay/ pay for needed dental treatment will not be refunded. However, if you are refusing and insist on a refund, you will be responsible for all charges incurred and may be accessed a cancellation fee. We have several payment methods we offer our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account, you will be responsible for all charges incurred.

Your cooperation and complying with these guidelines is appreciated. We are concerned primarily with your oral health, as well as taking your schedule into consideration. We believe these guidelines will best benefit every patient. It is our desire to serve each and every one without causing undue hardship for anyone.
Thank you for choosing our office for your dental care.

I have read the financial policy and pre-payment policy and agree to their content.

_____ _____

Signature of patient, parent, or guardian Date

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME OF PERSON TO RECEIVE INFORMATION:

CIRCLE INFORMATION TO BE DISCLOSED:

_____ Spouse (Name)	Dental	Financial	No Restrictions
_____ Parent (Name)	Dental	Financial	No Restrictions
_____ Other (Name)	Dental	Financial	No Restrictions

(If health information is NOT to be released, please write "*do not give out*" in space provided below.)

_____

Patient Rights:

- I may inspect or copy the protected health information to be disclosed as described
- I have the right to revoke this authorization at any time
- Revocation is not effective in cases where the information has been disclosed but will be effective going forward
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (You may refuse to sign this acknowledgement)

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

I have read the Consent and Authorization to Release Information and the Acknowledgement of Privacy Practices and agree to their content.

_____
Print Patient Name

_____
Signature of patient, parent or guardian

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of Notice Of Privacy Practices, but receipt was not obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify) _____