Welcome! So that we may provide you with the best possible care, please read and complete the FRONT and BACK of all pages given. All information is completely confidential.

OFFICE POLICY

New patients are asked to bring ALL necessary information regarding their insurance policy. We ask that you bring a list of any MEDICINES taken daily. If you know of any pre-medication that you must take before each dental appointment please inform us. We also ask that you notify the receptionist of any CHANGE OF ADDRESS, PHONE NUMBER, and INSURANCE INFORMATION OR MEDICAL HISTORY.

APPOINTMENT POLICY

Our office prides itself on staying on schedule. We ask all of our patients to be on time for their appointment. If you are more than ten (10) minutes late for any scheduled appointment, you may be rescheduled for another date and time. We find it necessary to have this policy in order to be fair to our other patients who arrive on time. We do require **24 hour notice** of any appointment that needs to be cancelled or rescheduled. If you fail to notify our office of a cancellation less than 24 hours prior to your scheduled visit, you will be charged a **$75.00 broken/missed appointment fee**. We find it necessary to charge this fee because less than **24 hour notice** makes it hard to fill your scheduled time with another patient. The $75 fee must be paid before being re-appointed. ANY PATIENTS who fail two (2) scheduled appointments may not be re-appointed.

PAYMENT POLICY

Payment is expected at the time of service unless other arrangements have been made in writing. If you have insurance, we will gladly bill them as a COURTESY but you are expected to pay in FULL your portion of the non-covered fees at the time the services are rendered. Our office accepts VISA, MASTERCARD, DISCOVER, CARE CREDIT and AMERICAN EXPRESS credit cards. In case of default of payment, I promise to pay legal fees and interest incurred to cover any collection cost up to 35% of the balance assigned. All unpaid balances will be charged 18% interest annually on all accounts exceeding sixty days from the date of service.

I have read and understand the above policies and agree to abide by the policies of this office.

____ Date:____________________

Signature of patient, parent or guardian

PATIENT REGISTRATION

Patient Name________________________________ Patient Birth date __________________ Sex________
Responsible Person__________________________________ Social Security Number____________________
Address______________________________City_______________________State_________Zip___________
Home Phone__________________ Work Phone__________________ Cell Phone____________________
Marital Status__________________________ Name of Spouse_____________________________________
Closest Relative____Phone______________________________
In Case of Emergency Contact_________________________________Phone___________________________
Who may we thank for referring you?___________________________ E-Mail________________________

Insurance Information

(If you have insurance please complete)

	1st Insurance	2nd Insurance
Insurance	______________________	______________________
Insurance Address	______________________	______________________
Insurance Phone Number	______________________	______________________
Employee/Subscriber Name	______________________	______________________
Employee/Subscriber ID Number	______________________	______________________
Employee/Subscriber Birth date	______________________	______________________
Group Number	______________________	______________________
Place of Employment	______________________	______________________

Payment is expected at time of service unless prior arrangements have been approved.

1. **Cash, Check, MasterCard, VISA, Discover Card, American Express**
2. **Personalized Payment Plans available through Care Credit**. Please ask for an application.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

A $75 fee will be charged for missed or cancelled appointments if 24 hour notice is not given.

Signature____ Date_________________________

PATIENT CONSENT FORM

I understand that I have the rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect care by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights on HIPAA. I understand that you reserve the right to charge the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this __________ day of ____________, 20_____.

Print Patient Name: ______________________________

Relationship to Patient: ___________________________

Signature: ______________________________________

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