Patient Information Form

Today's Date _____

Patient Name: First_____MI_____Last_____Nickname _____

Address: Street_____City_____State_____Zip _____

Phone: Home_____Work_____Mobile _____

Social Security Number_____**Date of Birth** _____**Drivers License #**_____**State** _____

Patient Employed By_____Occupation_____Phone _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient_____Home Phone_____Mobile Phone _____

Whom may we thank for referring you to our office? _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First_____Last_____

Date of Birth_____**Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Dental Benefit Plan Information

Primary Dental Plan Name_____Phone _____

Insured_____Date of Birth_____ID Number _____

Policy Number_____Patient Relationship to Insured _____

Secondary Dental Plan Name_____Phone _____

Insured_____Date of Birth_____ID Number _____

Policy Number_____Patient Relationship to Insured _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

- **Payment:** Payment is due at the time services are rendered. A detailed separate financial policy agreement is included in this registration. *If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*
- **Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. **Our practice IS NOT a participating provider.** We will bill your insurance as a courtesy. Payment will be sent directly to you.
- **Scheduling of Appointments:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. Details are included in separate financial policy. **To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice.**
- **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

  __I consent and accept the risk in receiving information via email. __I consent only to receiving appointment reminders via email or text.

  I understand I can withdraw my consent at any time. **Email address is** _____
- **Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.____(initial)
- I have read the above and agree to the financial and scheduling terms.____(initial)
- I authorize the release of information necessary to process my dental benefit claims. __(initial)

Signature_____Date_____