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PATIENT INFORMATION

Name (Mr., Mrs., Ms., Dr.,) ______________________________
Last First Middle

Residence/Address ______________________ City ______________ Zip ____________

Business/Address ______________________ City ______________ Zip ____________

Home Phone # ______________________ Business Phone # ______________________

Cell Phone # ______________________ E-mail Address ______________________

Date of Birth ____ / ____ / ____ Social Security # ______________________

If patient is a minor, Name of mother and father ______________________

Place of Employment ______________________

Occupation/Former Occupation ______________________

SPOUSE INFORMATION

Name ______________________ Date of Birth ____ / ____ / ____

Employer ______________________ Occupation ______________________

In Case of Emergency

Person to Contact ______________________ Phone # ______________________

Friend/Relative Not Living with Patient ______________________ Phone # ______________________

REFERRAL SOURCE

Whom may we thank for referring you? ______________________

If not referred, how did you hear about us? ______________________

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible for Payment of Account ______________________ Relationship ______________________

Mailing Address ______________________ City ______________________ State ____________

Date of Birth ____ / ____ / ____ Phone # ______________________ Zip ____________

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan ______________________

Policy or Group # ______________ Subscriber's Name (if different) ______________ SSN of Subscriber ______________

Name of Secondary Dental Insurance Plan ______________________

Policy or Group # ______________ Subscriber's Name (if different) ______________ SSN of Subscriber ______________

There will be a charge for broken appointment without 72 hours notice. I understand that responsibly for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services.

Signature ______________________________ Date ____ / ____ / ____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1½% finance charge (18% APR) may be added to my account.

Patient ____________________ Date____ / ____ / ____ Witness ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefit.

If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

Patient ____________________ Date____ / ____ / ____

Parent or Responsible Party ____________________

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of New Image Dental to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Patient ____________________ Date____ / ____ / ____

Parent or Responsible Party ____________________

I understand that New Image Dental will make every effort possible to assist me with my insurance coverage. New Image Dental allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, New Image Dental will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or any other balance not paid by my insurance company. New Image Dental requires my estimated portion at the time treatment is rendered.

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 72 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 72 hours notice, I will either be required to pay a fee of $50 per scheduled hour before a new appointment time will be made for me, or be put on a short call list.

Patient ____________________ Date____ / ____ / ____

Parent or Responsible Party ____________________

- ☐ I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.
- ☐ Patient refused / was unable to sign because ____________________
- ☐ I have received a copy of the **DENTAL MATERIALS FACT SHEET** as required by law.

Patient ____________________ Date____ / ____ / ____

Parent or Responsible Party ____________________