Patient Information

Name:_____
Last First Preferred Name

Address:_____
Street City State Zip

Home # _____ Cell # _____

Email Address _____ Marital Status: [_} S [_] M [_] W [_] D

How would you like to be contacted (check all that apply): [_] Text [_] Phone Call [_] Email

SSN _____ Circle One: M F DOB: _____

Occupation:_____ Employer _____

Referred by / How did you hear about our office: _____

If under 18 who is Responsible for Account: _____

INSURANCE INFORMATION

Policy Holder Name _____ DOB_____ SSN_____

Insurance Company Name _____ Employer_____

Member ID # _____ Group # _____

Secondary Insurance Information

Policy Holder Name _____ DOB_____ SSN_____

Insurance Company Name _____ Employer_____

Member ID # _____ Group # _____

Privacy Practice

As required by the Privacy Regulations, Baxter Dental Associates has explained the "Notice Of Privacy Practices" to my satisfaction. I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I understand that I will be responsible for the full amount of my treatment fee regardless of the reason for non-payment from my dental plan. In the event insurance coverage terminates, differs from our estimated amount or changes in any way from the estimate, I will be responsible for the unpaid balance. I agree to be responsible for all charges for dental services not paid by my dental plan.

I understand in case of delinquency, I will be responsible for all legal and attorney fee's due on this account & will be turned over to a collection agency for non payment to the practice.

I understand this practice /clinic has the right to change their privacy practice and that I may obtain my revised notice at the practice/clinic.

I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic agrees to my request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s)

I also understand I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Signature:_____ Date_____

Print:_____

If signed by parent, state relationship to patient_____

OFFICE POLICY FOR MISSED APPOINTMENTS

When our office schedules an appointment for you, we are setting aside a dedicated chair and time slot just for you. We only ask that if you reschedule your appointment, that you please provide us with at least 24 hour and if we have more than an hour scheduled for you, please try to give us a 48 hour notice. This courtesy makes it possible to give your reserved time to a patient who would either have an emergency or need treatment.

CHARGES FOR NO SHOW APPT'S WILL APPLY

Every patient in our practice receives a unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangments to be ready for your visit. Except for emergency treatment for another patient, you can except us to be prompt. We, of course, would appreciate the same courtesy from our patients.

_____ _____

Name DATE