cp

[ ]Male [ ]Female Birth-date: _____ Social Security #: _____ [ ]Married [ ]Single [ ]Child

Contact Phone: _____ Account Phone: _____ Email:_____

Address: _____
Street City State Zip

Emergency Contact: _____
Name Phone Relationship

Referred by: _____ Date of last dental office visit: _____

My dental health is: [ ]Excellent [ ]Good [ ]Fair [ ]Poor Present Dental Problems: _____

If I could change my smile I would: _____ Reason I left my last dentist: _____

Guardian's Name:_____ Guardian's Phone:_____

Employer Name: _____ Occupation: _____

Consent for services: I have read and understand the information herein and to the best of my knowledge all the preceding answers are correct. As a condition of treatment by this office, I am prepared to and will pay the fees for services provided. The practice depends on reimbursement from patients for the costs incurred during dental care, and the financial responsibility is the patient's/patient's guardian's at the time of service. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patent, but as a courtesy our office will submit your dental claim. I hereby assign the benefits of my dental insurance to be paid directly to this office.

-**I grant to the office personnel permission to contact me** by phone, at work or at home; and by email, PUBLIC OR PRIVATE, AND SECURED OR UNSECURED, to communicate about matters of my dental care.

- I consent to have necessary X-Rays and Examination as required to verify my oral health or diagnose dental needs.

-**Cancellation policy:** A $50 cancellation fee will be charged for any cancelled or rescheduled appointment within 36 hours of the appointment.

-I have read and understand the information herein and give my consent for dental services. If I or my dependent receive dental treatment I understand that there may be unforeseen situations that arise where dental treatment, planned or diagnosed, may change during treatment.

_____ _____ Date: _____
PRINT NAME Signature of Patient (or Guardian/Responsible Party)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited us from obtained acknowledgment

Other (Please Specify)

_____	_____
Employee Name	Office Name
_____	_____
Employee Signature	Date