Welcome To Artistic Dentistry

Please Complete the Following ***Confidential*** *Patient Registration Information*

Patient Name ______________________ **Name you prefer to be called:** ____________

First MI Last

Home Address ______________________

City, State, Zip ______________________

Home Phone ____________ **Work Phone** ____________ **Cell** ____________

Birthdate ____________ **Please Circle** Male Female

Social Security # ____________ Single Married Divorced Widowed Other

Whom may we Thank for Referring You? ____________ **Spouse's Name** ____________

Person to Contact in Case of Emergency? ____________ **Contact Phone** ____________

Preferred Pharmacy & Cross Streets: ____________ **Phone** ____________

Please Complete the Following ***Confidential*** *Contact Information*

Email Address ______________________

Please circle your contact preference: Home Ph. (call,voicemail) Cell Ph (call,voicemail) Email Text

Please indicate any Person with whom you give us permission to discuss your Dental Treatment, Appointments or Fees:

Name ____________ Phone ____________ Relation ____________

If you Have ***Dental Insurance,*** *Please Complete the Following Information*

Name of Insured ____________ Relationship to Patient ____________

Social Security or ID # of Insured ____________ Birthdate of Insured ____________

Employer or Group Name ____________ Group Number ____________

Insurance Company Name ____________ Insurance Phone # ____________

******If you have coverage with more than one Dental Insurance Company, Please let us know.******

Please read and sign below to acknowledge your ***HIPAA*** *rights*

My signature below indicates that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I acknowledge that I have been offered a copy of the Federal HIPAA guidelines.

Printed Name ______________________ **Date** ____________

Signature ______________________

Please read and sign below for ***Authorization, Release, and Agreement to Pay for Services***

I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior financing has been made. I agree to pay a billing fee, if balance is not paid within 35 days of the monthly billing date. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I authorize this office to leave messages and/or mail correspondence to remind me of upcoming appointments. I understand that a broken appointment fee of $35.00 may be charged to my account if I miss an appointment or cancel with less than 48 hours notice.

Signature ______________________ **Date** ____________