Artistic Dentistry
cosmetic | implants | sedation

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

Patient Name _____ (First / MI / Last) **Name you prefer to be called:** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Phone Numbers **Home** _____ **Cell** _____

Email Address _____

Birthdate _____ **Social Security #** _____

Gender ☐Male ☐Female ☐Other **Relationship Status** ☐Single ☐Married ☐Divorced ☐Widowed

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

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

Please indicate Person(s) with whom you give us permission to discuss your Dental Care, Appointments or Fees:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

****Please complete information below if you have DENTAL insurance****

Subscriber Name _____ **Subscriber Date of Birth** _____

Insurance Company _____ **Group Number** _____

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

My signature below indicates that I acknowledge Artistic Dentistry follows the Health Insurance Portability & Accountability Act of 1996(HIPAA) with my personal health information. I understand that I may request a full printed copy of the Notice of Privacy and it is available to read on the website ***www.artisticdentistryaz.com*** under Patient Forms.

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 financial arrangements have 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** _____