Patient Full Name: _______________________________________Preferred Name: _________________

Parent or Guardian Name(s)(if patient is a minor – 18 & under):____

Date of Birth:_______________________________ Social Security Number: ________-_____-______________________________

Mailing Address : ____

Home Phone: __________________________Cell Phone:__________________________Work Phone: ____________________

Email Address: _____________________________

Marital Status: (Married/Divorced/Widow/Single)   Employer: _____________________________

Who may we thank for referring you to our office? ____

Primary Dental Insurance Information (Leave blank if there is no dental insurance to file)

Insurance Company Name: ____

Name of Subscriber (Person who carries the insurance): _____________________________________

Subscriber's Social Security Number: _____-____-______ Subscriber's DOB: _____________________

Subscriber's ID Number: ___________________________ Group Number: _______________________

Subscriber's Employer: ____

Policy for Filing Insurance

Our office has never been in network with any dental insurance providers, however as a courtesy we will file your claim. You will be responsible for any chargers your insurance does not pay. If for any reason your insurance company has not paid within 60 days of treatment the balance will be your responsibility and you will need to re-file with your insurance company. The patient's estimated portion will be due at the time of service.

Payment Services

If you are a self-pay patient with no dental coverage all financial responsibility must be paid at the time of service. In the event you do have insurance but are unable to provide us with the insurance card you may be asked to pay in full at the time of service. When insurance is provided we give an estimate to the best of our knowledge. In the event insurance does not pay in full you are responsible for the balance. All balances on accounts must be paid within 30 days. All delinquent accounts will be subject to being turned over to a collection agency.

By signing below, I attest that the above information is correct to the best of my knowledge. I also understand that payment is due when services are rendered and that I will be responsible for any amount that insurance does not cover.

Responsible Party Signature: ____ Date: ____________________________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION OR FINANCIAL INFORMATION

Patient Name of Patient: ____Date of Birth: _______________

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical and/or financial matters. This is to acknowledge that you authorize Piedmont Dental to disclose your private health information to the following individuals.

Name: ______________________________________ Relationship to patient: _______________________

Telephone: __________________________________

Name: ______________________________________ Relationship to patient: ________________________

Telephone: __________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Piedmont Dental is committed to protecting your privacy. We will not release any information about you or your treatment without your consent. Only the people you list will be authorized to receive your information. I acknowledge that a copy of this office's Notice of Privacy Practices is available to me upon request.

Patient or Responsible Party: _____________________________________ Date: _____________________

BROKEN APPOINTMENT AND CANCELLATION POLICY

We hold appointment times especially for you in good faith that you will be here. When patients do not show up or cancel at the last minute (regardless of the reason) we cannot fill the open slot. This results in nonproductive time with results in increased fees for everyone. We appreciate your understanding. There will be a $50 charge for ALL missed appointments and cancellations with less than 48 business hours prior to the scheduled appointment time.

Patient or Responsible Party: _______________________________________ Date:______________________