Patient Information

Patient # _____
SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Cell Phone _____

Email _____ State _____ Zip _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or parent/guardian's employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Spouse/Parent/Guardian's name _____ Employer _____ Work phone _____

Emergency contact _____ Phone _____

Preferred Pharmacy _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address _____ Home phone _____ Cell Phone _____

Email _____ Birthdate _____ State _____ Zip _____

Are you currently a patient in our office? ☐ Yes ☐ No Driver's license # _____

Employer _____ Work phone _____ SSN _____

We offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance _____ Group# _____ Policy/ID# _____

Insurance address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If **YES**, complete the following:

Insurance _____ Group# _____ Policy/ID# _____

Thank you for selecting our dental healthcare team! If you have any questions or need assistance, please ask us - we will be happy to help.

Who may we thank for referring you? _____

Coulter Family Dentistry, Inc.

Office Policy, Consent and HIPAA Forms

Our office hours are: Monday – Thursday from 8am – 5pm. We are closed daily for lunch from 1pm – 2pm.

Office Policies:

***SCHEDULING APPOINTMENTS:** You are responsible to inform the office within (2) business days if you are unable to make your scheduled appointment. Any appointments scheduled on a Monday need to be canceled no later than 5pm on Thursday to avoid a cancellation fee. If you fail to show for an appointment or cancel last minute, the following actions will take place: **first violation** will be a **verbal warning**, **second violation** will result in a **$50 missed appointment fee,** and the **third violation** will result in **dismissal from the practice**.

***PAYMENT:** **We will file with most insurance companies but are not a participating provider**. All of our treatment plans are estimates and never a guarantee. Any remaining balance not paid by the insurance company is your responsibility. We provide treatment plans according to the limited information we receive from your insurance company. ***ESTIMATED CO-PAYS ARE DUE IN FULL AT THE TIME OF EACH APPOINTMENT**. You will be billed for any balance not received from your insurance company within (**60**) days of your treatment. Your account will be forwarded to an outside **COLLECTION AGENCY** if your balance is not paid in full within (**90**) days. You will then be responsible for all legal fees, interest and/or collection agency fees in addition to your balance. Returned checks will be charge a **$32.00 fee**. **Please understand the importance of knowing your own insurance plan. It is your responsibility.**

***Warranty: In order for us to stand behind our treatment, you MUST maintain your routine care appointments. This includes bi-annual cleanings, x-rays, exams, and the use of a night guard if recommended.**

Patient Signature: _____ Date: _____

Consent for Treatment:

1. **I authorize** Dr. Brian Coulter or designated staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Brian Coulter to make a thorough diagnosis of **(Patient name printed) _____**'s needs.
2. Upon such diagnosis, I authorize Dr. Brian Coulter to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of my service unless other arrangements have been made. In the event that payments are not received by the agreed upon date, I understand that a late charge and 18% APR may be added to my account.

Patient Name: _____ Date: _____

Patient or Responsible Party: _____ Relationship to Patient:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

****You may refuse to sign this acknowledgment****

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

Print Name: _____Signature_____ Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgment of receipt of our notice of Privacy Practices Acknowledgment could not be obtained because:

•Individual refused to sign •Communication barriers •An emergency situation prevented us from obtaining acknowledgment. •OTHER: _____