Patient Information (CONFIDENTIAL)

*Date*____________________________________

Please Print

Soc. Sec # ____________________________________

*Name*__________________________________*D/O/B*______/_____/_____*Age*______*Home Phone*_________________

Last *First* *MI* *Cell Phone*__________________

*Address*____*City*______________*State*___*Zip*____ *Check Appropriate box:*

☐ *Single* ☐ *Married* ☐ *Widowed* *E-mail Address*_________________

May we contact you via email Yes ☐ *or No* ☐

*Patient or Parent's Employer*________________________*Occupation*______________*Work Phone* ________________

*Spouse or Parent's Name*_______________________*Employer*_____________________*Work Phone* _____________

Whom May We Thank For Referring You? ____

*Who is your general dentist?*____*How long?* _____________________

*Person to Contact in Case of Emergency*__________________________________*Phone* _________________________

Responsible Party

*Name of Person Responsible for this Account*____________________________*Relationship to Patient* _________________________

*Employer*____*Work Phone* _______________________

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

Dental Insurance Information

*Insurance Company*____*Group #* ___________________________

*Ins.Co Address*______________________________*City*________________*State*_________*Zip*__________________

Ins. Co Phone Number ____

*Name of Insured*____*Relationship to Patient* _________________________

*Birthdate*________________*SSN# or ID#*____________________________*Date Employed* ____________________

*Name of Employer*____*Work Phone* _______________________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ *YES* ☐ *NO IF YES, COMPLETE THE FOLLOWING*:

*Insurance Company*____*Group #* ____________________________

*Ins. Co Address*______________________________*City*________________ *State*______*Zip* ___________________

Ins. Co Phone Number ____

*Name of Insured*____*Relationship to Patient* __________________________

*Birthdate*_____________SSN# or ID#_________________________________*Date Employed* ______________________

*Name of Employer*____*Work Phone* _________________________

I understand that responsibility for payment of dental service in this office for myself and my dependents is mine: due and payable at the time of services are rendered unless prior financial arrangements have been made and discussed. I understand I am responsible for all costs of collection including attorney fees, collections fess of 30% and court costs. I understand that may unpaid balance will be assessed interest at the rate of 18% (1.5% monthly). Insurance claims are filed as a courtesy, but it my responsibility to see that the claims are paid. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I have been advised of my privacy right as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employee, agents and assignees to contact me and send any correspondence (including statements, consents, etc) via email, text messaging and to my cellular devices.

MISSED/CANCELLED APPOINTMENTS:

I understand that my first missed or cancelled appointment with less than 24 hours notice will incur no charge, my second missed or cancelled appointment with less than 24 hours notice will be charged $50.00/hr, and that any additional missed or cancelled appointments will be charged $75.00/hr.

RELEASE AND ASSIGNMENT:

I hereby authorize Woody Dental to release to my insurance company or its representative, any information and/or records of any treatment or examination rendered. I also authorize and request my insurance to directly pay the above named doctor the amount due for dental treatment or services.

I understand that I am financially responsible for all services rendered (except those covered under my benefit plan).

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Patient's signature (guardian's if minor) ***Date***