



### Patient Information

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_  M  F  Married  Single  Child  Other  
Last First MI

Social Security \_\_\_\_\_ Birth Date \_\_\_\_\_ E-Mail \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code  
Preferred appointment times:  Early Morning  Mid or Late Morning  Any Time  M  T  W  TH Confirm:  YES  NO

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

### Spouse or Responsible Party Information (If different than above)

Name: \_\_\_\_\_  M  F  Married  Single  Child  Other  
Last First M

Social Security \_\_\_\_\_ Birth Date \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Employer Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation: \_\_\_\_\_

### Dental Insurance Information

**DENTAL Primary Insurance:** Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First MI

Insured's Employer Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Insurance Company Name: \_\_\_\_\_ Phone \_\_\_\_\_ Group #: \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

**DENTAL Secondary or MEDICAL Insurance:** Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First MI

Insured's Employer Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Insurance Company Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Group #: \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

## Referral Information

Name of person or office referring you to our practice: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, payment must be made at the time the services are rendered, unless financial arrangements have been made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and/or assist the patient in obtaining reimbursement from the insurance company. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Appointments scheduled in our office are times reserved just for you. We trust no changes will be necessary. If you find it necessary to change your appointment time, please notify us at least 48 hours in advance so that time can be given to another patient.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Kathy L. Davies, I agree to pay the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be granted.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I certify that I have read and understand the above conditions of treatment and agree to their content.

I certify that I have completed this form to the best of my knowledge and I will not hold my dentist or any other member of her staff responsible for any errors or omissions I may have made herein.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.  
Print Name

I agree to have Dr. Kathy Davies, or any member of her dental team, share my private and protected health information (PHI) with: My other health care providers and/or insurance company \_\_\_\_\_  YES  NO

My spouse (name) \_\_\_\_\_  YES  NO

Other family members (names) \_\_\_\_\_  YES  NO

\_\_\_\_\_  
Signature of **patient**, parent or guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of **Insured** person

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

#### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_