PATIENT INFORMATION

Name:_____

Last First Middle Initial

Date of Birth:_____ **SSN:**_____

Marital Status: Single Married Divorced Widowed Domestic Partner

Address:_____**City**_____**State**_____
Zip Code_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Email:_____ **Employer:**_____

Emergency Contact:_____ **Phone Number:**_____

Relationship to patient:_____

INSURANCE INFORMATION

Dental Insurance Company:_____

Employer:_____ **Subscriber:**_____

Relationship to patient:_____ **Subscriber DOB:**_____

Subscriber SSN or ID No.:_____ **Phone Number:**_____

Address (if different from patient):_____

Do you have additional/secondary dental insurance? If so, Name and subscriber:_____

_____

FINANCIAL POLICY

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in our office. The patient is responsible for all charges that are denied or unpaid by your insurance carrier. Most dental insurances have limits and/or various degrees of co-payments.

INSURANCE COVERAGE: I understand my dental insurance is a contract between the insurance carrier and the patient, not between doctors and the insurance carrier. NO INDIVIDUAL in this office can predict what our insurance will or will not pay. Insurance companies indicate that there is no guarantee of coverage until the actual claim is received. Therefore, I will be responsible for payments that a third party may refuse to pay. _____Initials

PAYMENT TERMS: I understand that I am financially responsible for all charges incurred by my dependents and /or myself AT THE TIME SERVICES ARE RENDERED. I agree that in the event my account is past due ninety days from the date of service, I will be turned over to a collection agency unless arrangements are made in advance. Late charges and collection agency charges do apply. We accept cash, checks, MasterCard, Visa, American Express, and Discover. A fee of $35.00 will be charged on all returned checks. _____Initials

CANCELLATION POLICY: I understand that if I am unable to keep an appointment, I must kindly provide Cottingham Family Dentistry with a minimum of two (2) business days. This courtesy on your part will make it possible to give your appointment to another patient who needs to be treated by the dentist or hygienist. Our policy is after three missed appointments you will be required to pre-pay for all future services before an appointment time is held.
_____Initials

PROTECTED HEALTH INFORMATION:

Please distinguish any person/persons to whom you authorize Cottingham Family Dentistry to release your **protected health and/or financial information**. **Please be specific:**

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (you may refuse to sign this acknowledgement):

I have received a copy of this office's Notice of Privacy Practices (HIPAA):

_____ _____

Signature Date

CONSENT TO TREATMENT: I give Cottingham Family Dentistry the authority to administer xrays, local injections, and anesthetics in relation to any needed treatment. If I have a medical condition, such as a heart murmur or artificial joint that requires premedication, or drug allergy, I acknowledge that it is my responsibility to inform and remind the Doctor, Assistant or Hygienist every time before treatment. Please advise our office of ANY and ALL medications you may be taking especially any blood thinners.

_____ _____

Signature Date