Patient Information

Patient Name: ____ Date: ___________
Last First MI (Preferred Name)

Gender: **Male/Female** Marital Status: **S/M/D/W**

Social Security #: _________________________ Birth Date: _______________________

Phone: ______________Work: ______________Cell: ______________Email: ____________________

Address: ____
Street Apartment #

____
City State Zip Code

In the event of an emergency please contact:

1) Name: ______________________________________Relationship: ______________________Phone: _________________

2) Name: ______________________________________Relationship: ______________________Phone: _________________

Responsible Party

☐Check box if information is the same as above

Patient Name: ____ Date: ___________
Last First MI (Preferred Name)

Gender: **Male/Female** Marital Status: **S/M/D/W**

Social Security #: _________________________ Birth Date: _______________________

Phone: ______________Work: ______________ Cell: ______________ Email: ________________

Address: ____
Street Apartment #

____
City State Zip Code

Dental Insurance Information

Primary

Policy holder: ____ Birth Date: _________________SS#:___________________
Last First MI

Insurance Company & Phone number:____ID#:__________________________

Policy holder's Employer: ___________________________Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary

Policy holder: ____ Birth Date: _________________SS:____________________
Last First MI

Insurance Company & Phone number:____ID#:__________________________

Policy holder's Employer: ___________________________Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Website ☐ Dental Office ☐ Yellow Pages
☐ Newspaper ☐ School ☐ Work ☐ Other ____

Name of person or office referring you to our practice: ____

PLEASE READ CAREFULLY BEFORE SIGNING

PATIENT INSURANCE AUTHORIZATION

The authorization below allows the insurance manager of Gabe Nabors, D.D.S and Jared Smith, D.D.S. to file and sign insurance claims. This authorization must be signed by the insured. Please read carefully before signing.

The undersigned hereby authorizes the insurance manager of Gabe Nabors, D.D.S and Jared Smith, D.D.S. as the undersigned's attorney-in-fact, to apply for, collect and apply to the undersigned's or any member of the undersigned's family under contract of insurance covering such person for any services performed at the office of Gabe Nabors, D.D.S and Jared Smith, D.D.S. The authorization shall remain in full force and effect until written notice of its revocation is received by the office of Gabe Nabors, D.D.S and Jared Smith, D.D.S.

FINANCIAL POLICY

As a condition of treatment by this office, I understand financial arrangements must be made in advance. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at time of service. ***Minors: The parent or guardian who brings the child to this office for treatment is the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, I am responsible for seeking reimbursement for payment made to this office.*** We will be happy to assist you by providing you with a copy of the charges and payments made at each visit.

If I carry insurance, I understand that this office will help prepare my insurance forms to assist in collecting payment from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by the insurance company. If agreement is made to accept insurance assignment, the account is due and payable within sixty (60) days of the treatment date. I understand my insurance coverage is an estimate and the actual cost may be more or less. I am responsible for all amounts not covered by my insurance carrier and it is my responsibility to know my insurance limitations and year-to-date maximum amount and amount used. If you have visited another dentist during your calendar coverage year, benefits used will not be reflected in this estimate. Year-to-date benefits used and remaining deductible amounts are not affected until the procedure is completed.

In consideration of the professional services rendered to me, or at my request, by the Doctor or his staff, I agree to pay the fee at time of service or if payment arrangements are made, to fulfill financial obligations that are agreed upon. **Effective Dec 1st, 2014, a $25 late fee will be assessed on any past due balances that are not paid in full by the 10th of each month.** I further agree that in the event I do not fulfill my financial obligations and collection action is taken, I am fully responsible for any costs incurred or if this office or I institute any legal proceedings with respect to the amount owed by me for services rendered, the prevailing party shall be entitled to recover all costs incurred including reasonable attorney fees.

I grant my permission to you, or your assigns, to contact me at home, work or on my cell to discuss matters related to this form.

APPOINTMENT CANCELLATIONS

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our doctor & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments and those appointments not cancelled within 24 hours. **Effective June 1st, 2014, a $50 fee will be assessed if we do not receive a 24 hour cancellation notice.** Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

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I have read the above conditions and agree to their content.

____DATE__________________

Signature of patient/ parent or guardian (If patient is a minor)

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

____ Date: _________________

Signature of patient/ parent or guardian (If patient is a minor)

If you wish to opt out of this feature, please fill out the REVOCATION section below.

REVOCATION

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

____ Date: _________________

Signature of patient/ parent or guardian (If patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE FOR HEALTH INFORMATION

I have received a copy of this office's Notice of Privacy Practices. After reading the Notice of Privacy Practices and having full opportunity to consider the contents of this notice, please sign below for consent. By signing below, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You do have the right to revoke this consent at a later date if desired. **Please list the names of facility/person with which we may discuss your health/billing information. Please note unless a specific name is listed we <u>cannot</u> discuss your information.**

	NAME	RELATIONSHIP	CONTACT NUMBER
1			
2			
3			
4			

____DATE____________________

Signature of patient/ parent or guardian (If patient is a minor)

For office use only: *Written disclosure was not obtained due to: ____Refusal to sign ____Communications barrier ____Emergency occurred ____Other*