PATIENT'S NAME_____ BIRTHDATE _____

HOME #_____CELL #_____WORK_____

***PLEASE CIRCLE BEST PHONE NUMBER IN WHICH YOU CAN BE REACHED**

GENDER_____HOW DID YOU HEAR ABOUT OUR OFFICE_____

SS# _____ EMAIL:_____

MAILING ADDRESS_____

CITY _____STATE _____ ZIP _____

WHOM TO CONTACT IN CASE OF EMERGENCY? NAME_____

RELATIONSHIP_____PHONE_____CELL_____

NEW PATIENTS:

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE TO THE FRONT DESK SO THAT WE MAY ENTER YOUR INFORMATION INTO YOUR DIGITAL CHART. IF NO INSURANCE COVERAGE, PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE OFFER 10% CASH DISCOUNT WHEN NO INSURANCE BENEFITS ARE AVAILABLE.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES PROVIDED. **I ALSO UNDERSTAND THAT IF I DO NOT HAVE INSURANCE MY BALANCE IS DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED.**

FOR THOSE WITH INSURANCE COVERAGE WE PROVIDE TREATMENT PLANS AND FINANCIAL ***ESTIMATES*** BASED ON THE INFORMATION RECEIVED BY YOUR INSURANCE COMPANY. WE WILL PROVIDE YOU WITH THE MOST ACCURATE ***ESTIMATE*** POSSIBLE TO HELP YOU WITH YOUR TREATMENT DECISIONS. HOWEVER, FACTORS WE MAY BE UNAWARE OF MAY AFFECT YOUR COVERAGE BENEFITS. IT'S YOUR RESPONSIBILITY TO KNOW THE DETAILS OF YOUR INSURANCE PLAN. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT YOUR INSURANCE COMPANY. THANK YOU!!!

UNPAID BALANCES OF UP TO 90 DAYS ARE PLACED WITH A COLLECTIONS AGENCY FOR SUIT. TERMS OF OUR COLLECTIONS: A FINANCE CHARGE OF 18% (MONTHLY) WILL BE ADDED TO THE UNPAID BALANCE EVERY 30 DAYS FROM DATE OF SERVICE. SHOULD COLLECTION BECOME NECESSARY, THE RESPONSIBLE PARTY AGREES TO PAY AN ADDITIONAL 40% COLLECTION FEE, AND ALL LEGAL FEES, WITH OR WITHOUT SUIT, INCLUDING ATTORNEY FEES AND COURT COSTS. I CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT PAYMENT ACTIVITIES.

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE, AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE AND TREATMENT TO ANOTHER DENTIST.

I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

_____ DATE_____
SIGNATURE

_____ DATE_____
PARENT (IF MINOR)

INSURANCE INFORMATION

PERSON CARRYING INSURANCE _____ THEIR BIRTHDAY _____

INSURANCE COMPANY_____EMPLOYER_____

GROUP # _____ SUBSCRIBER/ MEMBER ID _____

PATIENTS RELATIONSHIP TO SUBSCRIBER _____

SECONDARY INSURANCE _____ GROUP # _____

SUBSCRIBER ID _____ RELATIONSHIP _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I REQUEST AND AUTHORIZE MY HEALTH CARE INFORMATION TO BE RELEASED TO:

NAME:_____

RELATIONSHIP: _____

I may cancel this authorization to the extent of the law. If I do, I understand that the doctor/practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor/practice in reliance on my original authorization.
Once the doctor gives out the information that I have authorized to release, I know that the doctor has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal and State privacy laws may no longer protect the information.

_____DATE_____
SIGNATURE

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of health information. If you have any objections, please ask to speak with our HIPPA compliance representative. Your signature below is only acknowledgement that you understand this.

_____DATE_____
SIGNATURE

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality individualized dental care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to dental care in a timely manner. We would like to inform you of our office policy regarding missed appointments. The policy enables us to better utilize available appointments for our patients in need of dental care.
In order to be respectful of the dental needs of other patients, please be courteous and call our office at least 24 hours in advance. For those that do not do this there will be charges that will need to be paid before appointment is rescheduled. **Our fees are $35 for failed cleanings and $50 per hour for failed doctor appointments.**
For your convenience we do have an answering machine for you to leave a message if we are not in the office when you call.

_____DATE_____
SIGNATURE

1480 Orchard Drive, Suite 110, Bountiful, UT 84010 801.295.9500 | www.levodental.com