DATE______________
PATIENT NAME_____________________________ BIRTHDATE__________SEX--M_____F_______
PREFERRED NAME_________________________SS#____
ADDRESS______________________________CITY_______________________ZIP________________
HOME PHONE________________CELL PHONE_______________WORK PHONE________________
MARITAL STATUS__________________NAME OF SPOUSE__________________________________
EMAIL ADDRESS____
NAME OF RESPONSIBLE PARTY ON ACCOUNT____
IF CHILD UNDER AGE 21, NAMES OF BOTH PARENTS____________________________________

CHECK YOUR PREFERENCE FOR REMINDER CALLS

HOME PHONE_______CELL PHONE_______WORK PHONE________

LIST NAMES OF THOSE YOU ALLOW TO HAVE ACCESS TO YOUR PATIENT RECORDS____
PATIENT EMPLOYED BY_________________________BUSINESS ADDRESS__________________ __
PRESENT POSITION____HOW LONG________________
SPOUSE/PARENT EMPLOYED BY________________________________PHONE__________________
BUSINESS ADDRESS_________________________________PRESENT POSITION__________________
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ______________________________
PHONE NUMBERS OF EMERGENCY CONTACT-CELL____________HOME__________WORK___
NAME OF YOUR PHYSICIAN____
HOW DID YOU HEAR ABOUT OUR OFFICE? PLEASE CHECK-MARK.
FACEBOOK__SUBDIVISION NEWSLETTER__GOOGLE__WEBSITE__SIGN__OTHER__
NAME OF PERSON WHO REFERRED YOU TO OUR OFFICE____________________________________

PRIVACY POLICY

A COPY OF THE PRIVACY POLICYAVAILABLE AT CHECK IN. PLEASE SIGN THIS ACKNOWLEDGEMENT IN ORDER FOR US TO PROCESS YOUR INSURANCE. YOU MAY REFUSE TO SIGN, AND SELF PAY.

I_____________________________________have reviewed a copy of this office's notice of privacy practices for myself or my minor child (name of child)____________________.

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(SIGNATURE)

I AUTHORIZE RELEASE OF INFORMATION RELATING TO ANY INSURANCE CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT AND THAT IT IS MY RESPONSIBILITY TO VERIFY MY INSURANCE AND UNDERSTAND MY COVERAGE. I AUTHORIZE INSURANCE PAYMENT DIRECTLY TO JAMIE L. THURMAN-TAYLOR DDS OR ERICA R. KETCHEM DDS, OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THERE IS A $25 RETURNED CHECK FEE AND THAT I WOULD BE ON A CASH ONLY BASIS THEREAFTER. I UNDERSTAND THAT IF I AM TURNED TO A COLLECTION AGENCY BY THIS OFFICE IT WILL BE AT THE DISCRETION OF TLC FAMILY DENTISTRY TO ACCEPT ME BACK INTO THE PRACTICE AND THAT THERE WOULD BE A SERVICE FEE FOR REINSTATEMENT APPLIED TO MY ACCOUNT. I ACKNOWLEDGE THAT IF INSURANCE COVERS ONLY PART OF THE DENTAL TREATMENT THE PATIENT PORTION WILL BE COLLECTED AT THE TIME OF THE APPOINTMENT.

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SIGNATURE DATE