# PATIENT INFORMATION

Patient Name: _____ Preferred Name:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Mailing Address:_____
Street City State Zip Code

Phone#: (Home)_____(Work)_____(Cell)_____

Email address: _____

Patient's Employer:_____Occupation_____

Employer Address:_____
Street City State Zip Code

In Emergency Contact:_____Relation to Patient: _____Phone#:_____

Whom may we thank for referring you to our practice? _____

**PERSON RESPONSIBLE FOR PAYMENT (If other than patient listed above)**

Name:_____Relation to Patient_____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Mailing Address:_____
Street City State Zip Code

**DENTAL INSURANCE**
**PLEASE GIVE RECEPTIONIST: CARD TO COPY OR OTHER IMPORTANT INSURANCE INFO**

Subscriber's Name_____Relation to Patient:_____
(Who's name is the insurance in?)

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Mailing Address:_____
Street City State Zip Code

Subscriber's Employer (Name and Address and Phone)_____
_____

Insurance Company: _____

Do you have secondary insurance? ☐Yes ☐No

**ASSIGNMENT OF BENEFITS, PAYMENT POLICY & MISSED APPOINTMENT POLICY**

Please read and sign this statement before we agree to accept assignment of benefits directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. If you have any questions, please ask us. *Thank you!*

**I understand and agree that I am responsible for the payment of all treatment fees on my account.*
**I understand that after the insurance company pays Dr. James P. Barnes, DDS, PA., there could still be a balance remaining, for which I am responsible.*
**If my insurance company fails to make payment within 60 days, I will be responsible for the <u>full amount</u> owed to Dr. James P. Barnes, DDS, PA.*

My signature below authorizes assignment of benefits and payment directly to either James P. Barnes DDS or Janel K. Barnes, DDS, as well as the release of any necessary information relating to my dental claim.

The information I have given is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether I have insurance or not. In the event that my account is <u>past due more than 60 days</u>, a collection fee will be charged. Returned checks will be charged a $15 handling fee.

A minimum charge of $35 will be made for missed appointments and appointments cancelled without 24 hours advance notice.

Signature _____ Date _____

---

**PATIENT RECORD OF DISCLOSURE**

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of the Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means (such as sending correspondence to the individual's office instead of to their home). Please notify staff if correspondence should be sent to a different address.

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply):**

PHONE: Home ____ Work: _____ Cell: _____

_____ OK to leave detailed information on voice mail or answering machine
_____ OK to leave detailed information with this person(s): _____

**RELATIVES AND/OR FRIENDS WITH ME AT APPOINTMENTS (circle one):**

MAY or MAY NOT be present during my exam and/or discussion of treatment

---

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____