*Lacey Family Dental*

# welcome

Patient's Name _____

Birthday _____ Age ____ Gender ____

Social Security # _____ - ____ - _____

Home Address _____

City _____ State ____ ZIP _____

Home Phone # _____

Cell Phone # _____

Work Phone # _____

Email _____

Prefer reminders by: Home / Work / Email / Cell / Text

Emergency Contact

Name _____

Relationship _____

Phone _____

Insurance Subscriber *(or person responsible for account)*

Name _____ Relation _____

SS# _____ DOB _____

Employer _____

Insurance Company _____

ID/Policy #_____ Group #_____

Subscriber's Phone # and Address (if different) _____

_____

_____

Is there any Secondary Insurance coverage? Yes / No

**How did you find us?** _____

## Consent to Office Policies

In order to provide you with dental treatment here at Lacey Family Dental, we need your consent to and acknowledgement of our office policies. ***Copies of the complete policies are posted in the reception area, available on our website, and are always available upon request.*** They are summarized below and we ask the patient (or parent/guardian) to initial for their consent/acknowledgement to each policy, and to sign at the bottom:

General Consent: This is consent to let us see you as a patient for mutually agreed upon treatment.

Please initial after reading _____

Financial Policy: You are responsible for payment for all services provided. Aside from the portion your dental benefits coverage may provide, ***full payment is due at the time of service*** unless other arrangements are made. Insurance benefits are always an ***estimate*** and any difference between estimated and actual coverage is your responsibility.

Please initial after reading _____

Cancellation Policy: At least 24 hours notice must be given for cancellations, otherwise a ***$45/hour cancellation fee will be assessed***. Two missed "no-show" appointments or short-notice cancellations may result in patient dismissal. Please arrive before your scheduled time.

Please initial after reading _____

Privacy Policy: I confirm that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I consent to the disclosure and use of my records (or my dependent's records) for uses as detailed in the Statement of Privacy Practices. ***I consent to allow voice/email messages***.

Please initial after reading _____

**I acknowledge and consent to these policies and confirm my understanding that the complete policies have been made available to me. I attest to the accuracy of all the information on this page.**

Signed _____ Dated _____