Machen Family DENTISTRY

Today's date:						
PATIENT INFORMATION						
Patient's Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name):		Birth Date: / /	Sex: ❑ M ❑ F	
Street Address:		Main Phone: ( )		Cell Phone (for text confirmations) if not listed as Main Phone: ( )		
P.O. Box:	City:	State:	ZIP Code:	Social Security No.:		
Occupation:	Employer:					
EMAIL:						
Chose clinic because/Referred to clinic by (please check one box):		❑Google	❑ Yelp	❑ Facebook		
❑ Family	❑ Friend	❑ Close to home/work	❑ Insurance Plan	❑ Other		
Whom may we thank for referring you to our office?						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Person responsible for bill:	Birth Date:	Address (if different):	Home Phone: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Employer:	Employer Address:	Employer Phone: ( )			
Name of primary insurance carrier (company):					
Subscriber's Name:	**Subscriber's S.S. No.:**	**Birth Date:**	**Group No.:**	**Policy No.:**	**Effective Date:**
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No:	Policy No:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

HIPAA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPAA NOTICE OF PRIVACY PRACTICE.

→ ***Patient/Guardian Signature*** ***Date***

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon, diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

→ ***Patient/Guardian Signature*** ***Date***

FINANCIAL INFORMATION

"I agree to pay my account in full at the time of services, unless Machen Family Dentistry agrees to other payment arrangements. I understand that Machen Family Dentistry will submit insurance benefits for payment only as a courtesy to me. If my account is assigned to a collection agency that sues to recover payment, I agree to pay a reasonable attorney's fee in the event default is entered 35% of the principal and interest on my account balance or $400.00, whichever is greater. If I contest entry of default, I agree that the court may award a reasonable attorney's fee under Idaho law and that this award may exceed the amount of the attorney's fees otherwise awarded in the event of default. I further agree to pay reasonable costs of suit. I also agree to pay a $20 processing fee if my account is assigned to a collection agency."

I accept responsibility for payment to Machen Family Dentistry for any portion of the account that the insurance carrier does not pay. In the event that I do not have dental insurance, I agree to accept responsibility for payment. All balances over 90 days will be accessed with an interest rate of 1.5% per month (18% A.P.R.).

A $25 fee will be charged to the account for all returned checks.

I have read and understand all stated financial policies of this office.

→ ***Patient/Guardian Signature*** ***Date***

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same residence):	Relation to Patient:	Home Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Machen Family Dentistry or insurance company to release any information required to process my claims.

→ ***Patient/Guardian Signature*** **Date**