Patient Information

Full Name_____ **Birth date** _____ **Age**_____

Female____ **Male**____ / **Single**____ **Married**____ **Social Security #**_____-_____-_____

Address_____**City** _____**State**_____ **Zip**_____

Home Phone #_____**Work #**_____ **Ext**_____ **Cell** _____

Name of Employer _____**Email Address**_____

How did you hear about us? _____

Responsible Party Information (if patient is a child)

Name_____ **Relationship to patient**_____
Address_____**City/State**_____ **Zip**_____
SSN:_____-_____-_____ **Birth date**_____ **Home #**_____**Work #**_____**Cell #**_____

INSURANCE ESTIMATED CO-PAYS ARE DUE AT THE TIME OF SERVICE

THIS OFFICE WILL PREPARE YOUR INSURANCE CLAIMS AND WILL ASSIST YOU IN RECEIVING PAYMENT FROM YOUR INSURANCE COMPANY. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY AND UNDERSTANDING YOUR BENEFITS IS YOUR RESPONSIBILITY. IF YOUR INSURANCE DOES NOT PAY WITHIN 45 DAYS, YOU WILL BE RESPONSIBLE FOR THE BALANCE. I AUTHORIZE THE DENTIST OR HIS DESIGNEES TO RELEASE FINANCIALLY IDENTIFIABLE INFORMATION, TREATMENT DESCRIPTIONS AND INFORMATION, ELECTRONICALLY, FACSIMILE OR IN PAPER FORM TO MY INSURANCE CARRIER OR ANY RELATED ENTITIES THAT REQUIRE SUCH INFORMATION TO BE SUBMITTED.

Name of person who has the primary insurance; _____
Primary Insurance Company_____ SS# _____Group#_____
Insurance Company Address _____Phone # _____
Birth date of Insured: _____

Name of person who has the second insurance: _____
Secondary Insurance Company _____ SS# _____Group#_____
Insurance Company Address_____ Phone #_____
Birth date of Insured: _____

Financial agreement and consent: **I hereby assign and authorize payment of insurance benefits directly to Dr. Williamson. I understand that the fee estimated may change during treatment and fees can only be extended for a period of three months from the date of the patient examination.**
An 18% annual finance charge will be assessed on any unpaid balance over 60 days. Should collection become necessary, an additional 40% of the unpaid balance will be charged to cover our collection cost. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or collection attorney. I grant permission to you or your assignee to telephone me at home or workplace to matters related to this form. I also agree to allow this office to leave messages concerning appointments, insurance or results on my answering machine or with a family member. I consent to the diagnostic procedures and treatment by the dentist or assistants, as Dr Williamson deems necessary for proper dental care. This agreement supersedes all prior agreements signed.

HIPPA PRIVACY: I _____, HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONSENT FORM AND NOTICE OF PRIVACY PRACTICES, I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH AND DENTAL INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.
I AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREIN.

Signed_____ Date_____