PERSONAL HISTORY

Date: _____

Patient Name: _____

Address: _____

City/State: _____ **Zip Code:** _____

Sex: _____ **Marital Status (*circle one)*:** S M D W Sep

Spouse's Name: _____

Date of Birth: ____/____/____ **Home Phone:** _____

Social Security Number: ____-____-_____ **Cellular Phone:** _____

Employer: _____ **Work Phone:** _____

Occupation: _____

Employer Address: _____

City/State: _____ **Zip Code:** _____

Driver's License State/Number: _____

Email address: _____

Would you like to receive notifications from our office regarding appointments, treatment reminders, etc via EMAIL? Circle One Yes/No **via TEXT? Circle One** Yes/No

Referred By: _____

REASON FOR TODAY'S VISIT:

_____

_____

_____

_____

_____

_____

FINANCIALLY RESPONSIBLE PERSON

(if other than patient)

Responsible Person: _____

Relationship to Patient: _____

Address: _____

City/State: _____ **Zip Code:** _____

Sex: _____ **Marital Status (*circle one)*:** S M D W Sep

Spouse's Name: _____

Date of Birth: ____/____/____ **Home Phone:** _____

Social Security Number: ____-____-_____ **Cellular Phone:** _____

Employer: _____ **Work Phone:** _____

Occupation: _____

Employer Address: _____

City/State: _____ **Zip Code:** _____

Driver's License State/Number: _____

Email address: _____

Would you like to receive notifications from our office regarding appointments, treatment reminders, etc via EMAIL? Circle One Yes/No **via TEXT? Circle One** Yes/No

DENTAL INSURANCE INFORMATION

Insured Name: _____ **Social Security #:** ____-____-_____

Employer Name: _____ **ID#:** _____ **Group #:**_____

Insurance Co Name: _____ **Insurance Co Phone:** _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Do you have secondary insurance? Circle One Yes/No

Insured Name: _____ Social Security #: ____-____-_____

Employer Name: _____ ID#: _____ Group #:_____

2nd Insurance Co Name: _____ Insurance Co Phone: _____

2nd Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Insured Signature _____

Patient/Responsible Party Signature _____

Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Austin General Dentistry, PLLC

7800 North Mopac Expressway, Suite 330

Austin, Texas 78759

*******YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT********

I, _____, have been provided with a copy of Austin General Dentistry's Notice of Privacy Practices.

Patient/Responsible Party Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

A copy of these Notices is always available at the front office for viewing, and a hard copy can be provided to you at any time free of charge.

OFFICE USE ONLY:

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practice's Acknowledgement, but was unable to do so as documented below:

Date: _____ Reason: _____

Employee Initials: _____

CANCELLATION POLICY

If you are unable to keep an appointment, we kindly ask that you give our office at least 48 hours' notice of this cancellation to avoid a *failed appointment charge* of $25. We understand that issues may arise unexpectedly, and we will make every attempt to contact you via phone or email to confirm your appointment. It is your responsibility to inform our office of any changes in your contact information so that we will be able to successfully confirm your appointments. If we cannot contact you do to inadequate contact information, your appointment will be considered confirmed and a *failed appointment charge* will be incurred if you do not appear at your scheduled time. If a message is left and not returned, or a response email is not received regarding confirmation, your appointment will be considered confirmed and a *failed appointment charge* will be incurred if you do not appear at your scheduled time. After 2 failed appointments, we will no longer be obligated to appoint a scheduled time for your treatment.

LATE ARRIVAL

We understand that unexpected delays may occur when attempting to arrive at your appointment on time. We ask that you please contact the office as soon as possible to inform us of your late arrival. In an effort to see and treat all patients in a timely manner, appointments will be rescheduled for those arriving more than 15 minutes late. Consistent late arrivals will not be tolerated, and we will no longer be obligated to appoint a scheduled time for your treatment.

FINANCIAL POLICY

All account balances are considered past due after 30 days. Should the balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month the account is delinquent. A $30.00 service fee will be added for any returned checks, and only advanced payment in cash or by credit card will be accepted for payment thereafter.

Initials_____

INSURANCE POLICY

We are happy to accept insurance assignments if certain conditions are met: 1) the patient must satisfy his/her annual deductible, and 2) the patient understands that he/she is expected to pay for the estimated portion of the fee at the time of service, understanding also that is simply an *estimate*. If his/her insurance company does not pay in full for services within 60 days of treatment, the remaining balance will become the patient's responsibility. If the insurance payment does not meet the expected amount due, the patient is required to pay the remaining balance in full within 30 days. Should the balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month the account is delinquent.

ASSIGNMENT OF BENEFITS AGREEMENT

I understand that I am fully responsible for my account with Austin General Dentistry, PLLC. If my insurance benefits are denied, I will pay my account in full within 30 days. I understand that should my balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month my account is delinquent. I understand that assignment of benefits is a courtesy extended to me by Austin General Dentistry, PLLC, and I will give my full cooperation until my account is paid in full.

Agreement: I, _____, have read and understand all of the above policies of Austin General Dentistry, PLLC, and I agree to their terms.

Name of Patient: _____

Signature of Patient/Responsible Party: _____

Date: _____

GENERAL MEDIA RELEASE FORM

Patient Name: _____ **Date of Birth**: ___/___/___

In connection with dental services and/or treatment being rendered, I give permission for photographs to be taken of me, with the following stipulations:

1) The photographs shall be taken by my dentist or licensed dental technician under the dentists' direction.
2) The photographs shall be used for medical records and/or as educational material as deemed appropriate by my dentist.
3) I will not be identified by name in association with the photographs other than for medical records purposes.
4) Photographs may be retouched in any way the professional staff considers desirable.

Please initial all that apply:

_____ I understand and hereby consent to the above.

_____ I give additional consent for my photos to be used for marketing purposes, including on the Austin General Dentistry website. I understand that my identity will not be disclosed without further consent.

_____ I understand that Austin General Dentistry promotes their practice through Social Media. I consent to the use of photographs of me engaging in day to day operations at Austin General Dentistry. I understand that I might be identified by first name only, and that my privacy will be protected as per HIPAA regulations.

Patient/Responsible Party Signature _____

Date: _____