## PATIENT INFORMATION (CONFIDENTIAL)

Name________________________________________________________________Date_______________________

Address_________________________________City________________________State_________Zip__________________

E-mail____________________________Cell phone_________________________Home phone_______________________

SS#________________________Birthdate___________________Circle one:   Single   Married   Other

Employer_____________________________________________ Work phone_____________________________________

Emergency contact:_________________________________________ Phone_____________________________________

How/where did you learn about our practice?______________________________________________________________

## PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

☐ Same as above   ☐ Another patient in our office   ☐ A non-patient

***If other than patient***, Name_____________________________________Relationship_____________________________

***If different from above***, Address___________________________City_________________State_______Zip______________

E-mail____________________________Cell phone_________________________Home phone_______________________

SS#________________________Birthdate___________________Circle one:   Single   Married   Other

Employer_____________________________________________ Work phone_____________________________________

## PLEASE SIGN AFTER YOU HAVE READ THE FOLLOWING:

● To cover our up-front expenses until we receive your insurance payment, we ask that you ***pay your*** **estimated** ***patient portion at the time of service*** (or full amount if you do not have insurance) unless other arrangements have been made. We cannot know every detail of your policy and insurance companies reserve the right to deny payment in certain circumstances, so ***we cannot be responsible if the estimate we give you is different from the actual amount*** you will owe. By signing below, you authorize the insurance company for the above patient to pay any benefits due directly to us. If you have any questions about your insurance coverage, please contact your insurance company. We submit claims to your insurance company as a courtesy only.

● ***You are ultimately responsible for any amounts not covered by insurance***. We accept cash, checks, major credit/debit cards and Care Credit. A service charge of 1.5% (18% APR) may be applied to account balances not paid within 60 days. In the event that your account must be sent to a collection agency for non-payment, additional interest and fees may apply. A $25 service fee will be assessed for all returned checks.

●We respectfully request ***two business days' notice to change or cancel an appointment***. This allows us to make that time available to other patients that may have immediate needs. We reserve the right to charge a ***$40 broken appointment fee*** (amount subject to change without prior notice) to offset the cost of unused staff time.

●Our ***Privacy Practices*** are posted on our website and copies are available upon request. Your signature below acknowledges that you understand that you have access to full information about our Privacy Practices, that ***you consent to our use of your health information only for purposes of treatment, payment and healthcare operations***, and that you may revoke this consent at any time by giving written notice. Please list any individuals to whom we have your permission to give your personal information:_____________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Patient's (or Legal Guardian's) Signature   Print Patient Name   Date

***Birdwell & Mutlak Dentistry ● 990 Elliston Way, Suite 103 ● Thompsons Station, TN 37179 ● 615-550-4620***