Patient Full Name: ______________________________ Preferred Name:_____________________________
Parent or Guardian Name(s) (if patient is a minor – 18 & under):_____________________________________
Date of Birth: __________________________ Social Security Number: ________-_______-________
Mailing Address (Address,City,State,Zip):_ ____
Home Phone: _________________ Cell Phone: ____________________ Work Phone: _________________
Email Address: _________________________ Best Phone # to Reach You: Home Cell Work
Marital Status (Married/Divorced/Widow/Single) Employer: _________________________________
Who may we thank for referring you to our office? ____

Primary Dental Insurance Information (Leave blank if there is no Dental Insurance to file)
Insurance Company Name: ____
Name of Subscriber (Person who carries the insurance): ____
Subscriber's Social Security Number: _______-_______-_______Subscriber's DOB:_____________________
Subscriber's ID Number:__________________ Group Number: ___________________________________
Subscriber's Employer: ____

Secondary Dental Insurance Information (Leave blank if there is no Dental Insurance to file)
Insurance Company Name: ____
Name of Subscriber (Person who carries the Insurance): ____
Subscriber's Social Security Number: _________-______-_________ Subscriber's DOB: ________________
Subscriber's ID Number: _____________________ Group Number: ___________________________________
Subscriber's Employer: ____

Broken Appointment and Cancellation Policy

We hold appointment times especially for you in good faith that you will be here. When patients do not show up or cancel at the last minute (regardless of the reason) we cannot fill the open slot. This results in nonproductive time which results In increased fees for everyone. We appreciate your understanding. There will be a $25 or $50 charge for ALL missed appointments and cancellations with less than 24 business hours prior to the scheduled appointment time.

Policy for Filing Insurance

Our office is NOT in network with any dental insurance providers, however as a courtesy we will file to all dental insurance companies. You will be responsible for any charges your insurance does not pay. If for any reason your insurance company has not paid within 60 days of treatment the balance will be your responsibility and you will need to refile with your insurance company. The patient's estimated portion will be due at the time of service.

Payment Services

If you are a self-pay patient with no dental coverage all financial responsibility must be paid at the time of service. In the event you do have insurance but are unable to provide us with the insurance card you may be asked to pay in full at the time of service. When insurance is provided we give an estimate to the best of our knowledge. In the event insurance does not pay in full you are responsible for the balance. All balances on accounts must be paid within 30 days. All delinquent accounts will be sent to the magistrate's office or collection agency.

By Signing Below, I attest that the above information is correct to the best of my knowledge. I also understand that payment is due when services are rendered and that I will be responsible for any amount that insurance does not cover.

Responsible Party Signature: __________________________ Date: ___________

Krystal Teague Dental

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION OR FINANCIAL INFORMATION

Print Name of Patient: ___________________________________

Date of Birth: ________________________

I, ____________________________ authorize Krystal Teague Dental to disclose information related to my account or appointments to the following source of contact. By signing below I give permission for Krystal Teague Dental to contact me at my communication preferences.

Preferences	Initial Below
Email	
Home Phone	
Cell Phone	
Text Messages	

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical and financial matters. This is to acknowledge that you authorize Krystal Teague Dental to disclose your PHI to the following individuals.

Name:______________________ Relationship to patient: ___________________

Telephone:_________________

Types of Information: □ Appointment □Reminders □Health Information □ Financial Information

Name:______________________ Relationship to patient: ___________________

Telephone:_________________

Types of Information: □ Appointment □Reminders □Health Information □ Financial Information

Name:______________________ Relationship to patient: ___________________

Telephone:_________________

Types of Information: □ Appointments □Reminders □Health Information □ Financial Information

Acknowledgement of Receipt of Notice of Privacy Practices

Krystal Teague Dental is committed to protecting your privacy. We will not release any information about you or your treatment without your consent. Only the people you list will be authorized to receive your information. I have been given a copy of Krystal Teague Dental Notice of privacy and offered a copy to take home.

Patient or Responsible Party: ____________________________ Date: ___________