Nixa Smiles Dentistry
Patient Registration

PATIENT:

LAST_____FIRST_____MI_____DOB_____

ADDRESS_____

CITY_____STATE_____ZIP_____E-MAIL_____

TELEPHONE (HOME) _____(CELL)_____(WORK)_____

MAY WE: CONTACT YOU BY PHONE? ☐YES ☐NO LEAVE A MESSAGE? ☐YES ☐NO TEXT YOU? ☐YES ☐NO

HOW DID YOU HEAR ABOUT NIXA SMILES? _____

INSURED/RESPONSIBLE PARTY: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER_____

LAST_____FIRST_____MI_____DOB_____

ADDRESS_____

CITY_____STATE_____ZIP_____E-MAIL_____

TELEPHONE(HOME)_____(CELL)_____(WORK)_____

EMPLOYER:_____INSURANCE COMPANY_____

SOCIAL SECURITY #_____GROUP #_____

WHO IS AUTHORIZED TO RECEIVE INFORMATION ABOUT YOUR APPOINTMENTS/TREATMENT?

NAME PHONE RELATIONSHIP

_____

_____

AUTHORIZATION (please initial each line)

_____I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

_____I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

_____I hereby authorize payment of my insurance directly to the dentist or dental group otherwise payable to me.

_____I understand that my dental care insurance carrier or payer of my dental benefits **MAY PAY LESS** than the actual bill for services.

_____I understand **I AM FINANCIALLY RESPONSIBLE** for payments in full of all accounts.

_____I understand that there is a 24 hour cancellation/rescheduling policy in effect and that a fee of $25.00 may be charged when proper notice of cancellation is not provided.

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part my dental care payer. I attest to the accuracy of the information on this page.

I, _____ have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

WOULD YOU LIKE TO RECEIVE A COPY OF THE NOTICES OF PRIVACY PRACTICES? ☐YES ☐NO

SIGNATURE_____DATE_____

IF SIGNING AS PATIENT REPRESENTATIVE:

NAME_____RELATIONSHIP_____