New Leaf Dental

Registration Information for a Dependent

Patient Name: _____ ☐ Male ☐ Female
Last First MI Preferred Name

Soc Sec #:_____ Birth Date: _____Phone (Home):_____ (Cell): _____

Home Address:_____
Street City State Zip

Name of Parent of Guardian: _____ ☐ Male ☐ Female
Last First MI

Emergency Contact Name and Phone: _____
Name Phone Number

Other members of your immediate family who are patients in our office: _____

Who can we thank for referring you? _____

Responsible Party Information

Name:_____ ☐ Male ☐ Female Relationship to patient: _____
Last First

Address: _____
Street City State Zip

Soc Sec #:_____ Birth Date: _____Phone (Home):_____ (Cell): _____

E-Mail Address: _____ Would you like text/email reminders? ☐ Yes ☐ No

Employer Name: _____ ☐ Married ☐ Single ☐ Other

Work Phone Number: _____ Primary Insurance holder ☐ Secondary Insurance holder ☐

We require 24 hours notice for appointment cancellations. Appointment changes without adequate notice may be subject to a fee of up to $35.00, payable by the patient and not the insurance company.

Insurance Information

Primary Insurance Policy

Name of Policy Holder: _____ Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth: _____ Policy Holder's ID# _____ Group # _____

Policy Holder's Employer: _____ Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Company Name: _____ Phone #: _____

Secondary Insurance Policy

Name of Policy Holder: _____ Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth: _____ Policy Holder's ID# _____ Group # _____

Policy Holder's Employer: _____ Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Company Name: _____ Phone #: _____

At New Leaf Dental our primary goal is to help you maintain and improve your oral health. Regular exams and x-rays are all critical aspects of diagnosing oral problems such as cavities, infections, gum disease and oral cancers. Caring for our patients is something we take very seriously. To best serve our patients, the office policy is as follows.

Exams and X-rays frequency

New Patients require a complete oral exam and x-rays at the initial visit except in the case of emergencies as determined by the dentist. Existing patients- periodic exam every 6 months. X-rays are needed once per year.

Billing and Insurance Policy

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service. A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company; however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefit: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to New Leaf Dental of the insurance benefits otherwise payable to me.

Cancellation and No-Show Policy

We believe our time is valuable and strive to schedule appropriately for your appointments. We do understand there are times adjustments need to be made, and we're happy to accommodate a change request. However, we respectfully request at least a 24-hour notice for your cancellation. When you forget or cancel your appointment without enough notice, we miss the opportunity to fill that appointment time, and patients waiting for appointments cannot take advantage of the short notice opening. Therefore, we will require pre-payment when booking future appointments in these situations. If 3 or more violations to our Cancellations Policy occur, we reserve the right to remove you as a patient at New Leaf Dental.

Acknowledgement of receipt of Notice of Privacy Practices (HIPPA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by signing this consent I authorize New Leaf Dental to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X Signature of patient, parent or guardian: _____ Date: _____