Ottley Smiles Dental Center

Personal Information

Mr. /Mrs. /Ms /Miss /Dr._____
First Middle Initial Last

What name shall we call you? _____ Date of Birth _____/_____/_____

Patient Social Security #_____ Email _____

Home phone_____ Work phone_____ Cell phone_____

Address _____ City _____ State _____ Zip_____

Employer _____ Driver Lic # _____ State _____

Dental Policyholder _____ Relationship _____

Dental Policyholder Social Security# _____ DOB _____/_____/_____

Medical Policyholder _____

Medical Benefits Company _____ ID# _____

Credit Card (Master Card, Visa, or Discover)_____No._____ Exp_____

Person to contact in case of emergency_____ Phone # _____

How or from whom did you hear about us? _____

We do not have a billing service. **All fees not covered by insurance will be the patient's liability. All co-pays we share are only an estimate.** All payments can be made in cash, check, or we can charge the credit card listed above. We do not render services on the basis that the insurance companies will pay our fees. We will file insurance forms for you. **Payment is due when services are rendered unless other arrangements have been made.** If you must change a scheduled appointment, please inform us as soon as possible. **If we are not notified 24 hours on the working day prior to your appointment then we will, regrettably, cancel your appointment then each appointment that was cancelled will have a fee added to the account.** There will be a fee for any returned checks. In case of default, you will be responsible for all attorney and collection fees in an amount up to 50% of the debt to cover expenses once the account has been turned over to collections if no payment is made on your account. Above all else, all patients are responsible for knowing their insurance policy.

I hereby authorize Drs. Jared, Jonathan and Karina Ottley to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by them to make a thorough diagnosis of my dental needs. I also authorize Drs. Ottley to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I consent and authorize Drs. Ottley to use my photographs or any other image for education purposes.

I have received and have had full opportunity to read and consider the office's Notice of Privacy Practices. I understand that by signing this 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. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Drs. Jared, Jonathan, and Karina Ottley at Ottley Smiles Dental Center.

Patient Signature (Parent if Under 18 Yrs Old) _____

Date _____

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