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 Benefits Subscriber _____ Relationship _____

Dental Benefits Subscriber Social Security #_____ DOB ____/____/_____

Medical Benefits Subscriber _____Customer Service #_____

Medical Benefits Subscriber Social Security #_____ 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 due on or before the day of treatment. **All fees not covered by insurance 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 all 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 before 3:00 p.m. the working day prior to your appointment then we will, regrettably, charge your account. There will be a fee for any returned checks. An amount equal to 1.5% per month of any unpaid balance will be added to your account if the balance is over 60 days past due. By providing your credit card information above, this allows our office to automatically charge your credit card for any past due balances that you or a family member may incur. 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.

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 _____