Registration, Consent, Acknowledgments & Releases

PATIENT INFORMATION – a copy of driver's license or state issued ID is required to complete your patient file

Date _____ **Preferred Name/Nickname** _____

Last Name _____ **First** _____ **Middle** _____

Date of Birth _____ **Gender**: ☐ M ☐ F **SS#** _____ - ____ - _____ **DL#** _____
If Patient is a minor, SS# & DL# of Parent, Guardian or Personal Representative

Street Address (no P.O. Boxes)_____ **City, ST** _____ **Zip** _____

Mailing Address *if different from above*: **Address** _____**City, ST** _____ **Zip** _____

Home Phone # _____**Work Phone#** _____**Mobile Phone#** _____

Best time of day and phone number to reach you: _____

e-Mail (for appointment, office & billing correspondence only): _____ @ _____
If Patient is a minor, e-Mail of Parent, Guardian or Personal Representative

Check all that apply: ☐ Minor ☐ Married ☐ Domestic Partner ☐ Single ☐ Separated ☐ Divorced

Employer _____ **Occupation** _____
If Patient is a minor, Employer of Parent, Guardian or Personal Representative

Employer Address _____ **City, ST** _____ **Zip** _____

How did you hear about our office or whom can we thank for your referral? _____
Yelp _____ **Internet search** _____**Google** _____**Signage** _____**Sonoma Discoveries** _____ **Fundraiser** _____
Other (please be specific)_____

Spouse or Domestic Partner (parent or guardian if patient is a minor)

Last Name _____ **First** _____ **Middle** _____

Date of Birth _____ **Gender**: ☐ M ☐ F **SSN** _____ - ____ - _____ **DL #**_____

Employer _____ **Occupation** _____

Home Phone # _____**Work Phone #** _____**Mobile Phone #** _____

Emergency Contact that does not live with you:

Name _____ **Relationship to you** _____

Hm Phone # _____**Wk Phone #** _____**Mobile Phone #** _____

CONSENT FOR SERVICES

I hereby grant complete authority to Windsor Dental Group to administer treatment and to administer such X-rays, anesthetics and services to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my condition.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

(OVER, please)

11/28/16

Registration, Consent, Acknowledgments & Releases

AGREEMENT TO PAY FOR SERVICES

- **All services performed must be paid for at time of service unless a financial arrangement has been made in advance.**
- **Missed appointments, less that 24 hour notice day-of-appointment cancellations and changes are subject to a service charge.**
- **Returned checks and accounts referred to a third party collection service are subject to a service charge.**
- **Overdue accounts are subject to a service charge of 1% per month (18% per annum) on the unpaid balance.**
- **If litigation is necessary for collection of past due balances, the prevailing party shall be entitled to attorney's fees & costs.**

Patients with dental benefits:

- As a courtesy, we can submit your dental claims to your primary dental benefit plan. Please provide current and accurate information each time you receive treatment to assure prompt processing of claims.
- All dental benefit information you receive from any source is subject to change by your dental benefit plan at any time.
- No insurance company will guarantee payment until the dental claim has been paid. All dental services are your financial responsibility and you are responsible for payment in full for any amount not paid by your dental benefit plan. The total balance is due on the 60th day after treatment whether insurance has paid or not.
- Estimates given of expected dental benefits by this office do not relieve the patient of responsibility to pay for all services.

I have read and understand the above, Agreement to Pay for Services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

PHOTOGRAPHY RELEASE

I hereby authorize Windsor Dental Group to take photographs, slides and/or videos of my face, jaws & teeth. I understand that the photographs, slides and/or videos will be used as a record of my care and may be used for educational purposes and professional publications (dental journals and magazines). I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs, slides and/or videos.

I have read and understand the above, Photography Release.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

RECEIPT OF PRIVACY PRACTICES NOTICE & THE DENTAL MATERIALS FACT SHEET

I have received a copy of the Notice of Privacy Practices and a copy of the Dental Materials Fact Sheet for Windsor Dental Group.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

11/28/16