Date: _____

PATIENT INFORMATION (CONFIDENTIAL):

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Birth Date: _____ Social Security Number: _____

Please check one: Whom may we thank for referring you to our office? _____

- Minor Emergency contact name: _____
- Single
- Married Emergency contact number: _____

RESPONSIBLE PARTY (please fill out if it differs from patient):

Relationship to patient:

___ Self ___Spouse ___Parent ___Other

Name of the person financially responsible: _____

Social Security Number: Date of Birth:

PHARMACY INFORMATION:

Name: _____ Phone: _____
Address: _____

INSURANCE INFORMATION (if applicable):

Insurance Company Name: _____ Insurance Phone #: _____
Insurance Address: _____
City: _____ State_____ Zip code: _____
Plan Name/ Employer Name: _____ ID #/ SSN: _____
Policy Holder: _____ Date of Birth: _____ Group #: _____

Concerns/ Questions for the doctor:

Acknowledgement of receipt of HIPAA Notice of Privacy Practices

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name:

Relationship:

Name:

Relationship:

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION:**

VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Confirmation
- Text Messages to my Cell Phone
- Email Confirmation
- U.S Mail/Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED:

VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Confirmation
- Text Messages to my Cell Phone
- Email Confirmation
- U.S Mail/Postcard

Signature: _____

Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Please call us at (704)246-7551 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, an appointment will not be pre-appointed unless a $50.00 deposit is provided

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage. I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Serene Dental Spa Appointment Cancellation Policy.

Signature of patient Date