WELCOME TO Artisan Dentistry

First & Last Name (Please Print): _____

Date of Birth: _____-_____-_____ M

SSN: _____

Cell Phone: _____-_____-_____ Text? No

Work Phone: _____-_____-_____

Email: _____

Occupation: _____

Address: _____

Emergency Contact: _____

_____

Emergency Phone: _____-_____-_____

How did you hear about our office? _____

Referred By: _____

Primary **Dental Benefit Company Name**: _____ **Group/Policy #:** _____

Provider Phone Number: _____-_____-_____

Policy Holder's Name: _____

Policy Holder's DOB: _____-_____-_____

Policy Holder's ID or SSN: _____

Secondary **Dental Benefit Company Name**: _____ **Group/Policy #:** _____

Provider Phone Number: _____-_____-_____

Policy Holder's Name: _____

Policy Holder's DOB: _____-_____-_____

Policy Holder's ID or SSN: _____

Financial/Dental Benefit Policy: I understand that it is ultimately my responsibility to pay in full for all services rendered at the time of service. If I have dental benefits, I understand that my dental company will be billed on my behalf. However, any co-payment that I may have is due in full at the time of service, and any balances thereafter. I also understand that it is my responsibility to inform the office of any changes to my dental benefit information.

Appointment Reservations: As a courtesy, I will give Artisan Dentistry a **48 BUSINESS-HOUR NOTICE** of any changes or cancellations to my scheduled appointments. I understand that a $50 fee will be added to my account if I do not give Artisan Dentistry such notice. However, this fee may be waived due to special or emergency circumstances. I also understand that multiple cancellations may be cause for my dismissal from the practice.

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have received a copy of Artisan Dentistry Notice of Privacy Practices Authorization to Release Information. I authorize Artisan Dentistry to release information regarding the above named patient covered under the Privacy Act to people other than myself.

Authorization to Provide Treatment: I authorize the dental team at Artisan Dentistry to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

My signature below indicates that I understand and accept all of the above terms, and that the information I have given above is correct to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____-_____-_____