NEW PATIENT INFORMATION

Date_____

Patient's Name_____

Date of Birth _____ Sex M☐ F☐ Social Security # _____

Address_____

City_____ State_____ Zipcode_____

Home Phone #_____ Cellphone #_____

E-mail_____

Emergency Contact

Name_____

Phone Number_____

Relationship_____

Dental Insurance Information

Insurance Company Name_____

Subscriber's Name_____ Date of Birth_____

ID#_____ Social Security #_____

Employer Name_____ Relationship to Patient_____

REFERRED BY: GOOGLE☐ FACEBOOK☐ FAMILY MEMBER/FRIEND☐ _____

OTHER☐_____

I HAVE READ THE ABOVE INFORMATION AND AUTHORIZE THE PAYMENT TO THE DOCTOR NAMED ABOVE. I AUTHORIZE AND GIVE MY CONSENT FOR TREATMENT TO BE RENDERED BY THE DOCTOR NAMED ABOVE. I ALSO AUTHORIZE DR.BHOOMPALLI TO SUBMIT ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY DENTAL INSURANCE CLAIMS.

Signature_____ Date_____

Johns Creek Family Dentistry

OFFICE POLICIES

Welcome to our practice! We appreciate the trust you have placed in us.

Insurance

Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for the services is your responsibility. We will accept assignment of claims for primary insurance. All deductibles and fee amounts not covered by insurance are due at time of treatment.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation**. If at the end of 90 days, your insurance company has not paid, you are responsible for the entire balance.** Upon request, we will supply you with a copy of the claim so that you can resubmit if necessary.

In order to honor any insurance benefits, you must provide insurance identification and we must be able to verify the current benefits available**. Please be advised that you may be billed for services that your insurance will not cover due to exclusions or plan limitations.**

Office Fees

Payment is expected at the time service is rendered. We accept cash, Visa, MasterCard, American express, and Care Credit. **Our office does not take any personal checks**. If your account has been turned over to our collection agency a 4O% collection fee will be added to your account for the entire balance.

If you break an appointment with our practice, we ask for a 48 hour notice of cancellation. If we do not receive a 24 hour notice, you may be charged a $50 fee for the scheduled appointment. This fee cannot be charged to your insurance company.

I have read and understand the statements outlined above.

Signed_____Date_____

Notice of Privacy Practices

Patient Acknowledgement

Patient Name_____

Date of Birth_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. lf changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature:_____ Date:_____