Bagley Family Dentistry – Patient Update

Patient Information:

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
Email Address_____
Address: _____ City:_____ State: _____ Zip: _____
Date of Birth (M/D/Y): ____/____/_____ Gender: □M □ F Social Security Number (SSN): _____

Marital Status: □ Married □ Single □ Life Partner □ Minor
Spouse or Parent/Guardian (if minor) Name: _____
Emergency Contact: _____ Relationship: _____ Phone_____
REFERRED BY: _____

Employer Information:

Employer: _____ Phone: (____) _____Fax: (____)_____
Address: _____ City_____ State: _____Zip: _____

Health Insurance Information: *Please present your insurance card so we can photocopy it.*

Patient's Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other
Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____/____/_____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address_____ City_____ State: _____ Zip _____
Phone: (_____)_____Fax: (_____)_____

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? □ YES □ NO IF **YES**, PLEASE COMPLETE THIS SECTION
Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other
Name of Insured (First, MI, Last): _____ Insured DOB___/___/_____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address_____ City_____ State: _____ Zip _____
Phone :(_____)_____ Fax: (_____)_____

PRIMARY CARE DOCTOR: _____ Phone: _____

MEDICAL HISTORY UPDATE FORM:

We work hard to keep your medical contacts informed of your treatment progress and status. Please take time to inform us about any changes in your medical history and/or medications since your last visit.

Please list any NEW medical diagnoses below:

_____
_____
_____

Please list any NEW or CHANGES in your medications below:

_____
_____
_____

Patient Name: _____
Patient Signature: _____Date:_____
Signature Guardian/Responsible Party, if minor:_____
Print Guardian Name:_____Date:_____

APPOINTMENT POLICY:

I understand that all appointments with Bagley Family Dentistry MUST be confirmed within 48 of the scheduled appointment time. It is understood that the office staff will make every effort to confirm by all contact methods made available by me (i.e. home phone, cell phone, text messages and/or email).

If the office is unable to confirm any appointment in advance, I'm aware they reserve the right to cancel any and all upcoming appointments I may have.

If an appointment is confirmed and I do not show I am aware there will be **a $30.00** charge for each missed appointment unless an emergency situation occurs. It is also understood that Bagley Family Dentistry reserves the right to no longer treat me in this office after any no show appointment by me.

FINANCIAL AGREEMENT:

Payment is due at the time service is rendered. We accept cash, check, Visa, MasterCard, Discover and CareCredit.

I understand and acknowledge that I am full responsible for the payment of all costs associated with the services, treatment, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatment, procedures and/or diagnostic methods services are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatment, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

I understand all returned checks will be subject to a $30.00 returned check fee. Any account balance remain unpaid for 90 days from the day of service may be referred to a collection company or attorney. Please be aware that any unpaid balance will be referred to our collection agency and in that event I agree that I will be responsible of the cost of $15.95. In the event the balance is turned over to an attorney, I am also responsible for that fee.

I consent to the dentist use and disclosure of my health information to my insurance company or managed care company. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid balance has been assigned or referred by mail at any address that I provide to the dental office and/or by fax, email or phone number (whether a cell phone or landline) at any fax number, email, address or phone number that I provided to the dental office or any agent of the dental office.

Patient Signature:_____ Date:_____

Print Patient Name:_____

Guardian/Responsible Party, if minor:_____ Date:_____

Print Guardian Name:_____

HIPPA PATIENT ACKNOWLEDMENT:

(Must be filled out by a parent/guardian if the patient is under the age of 18)

We are required by law to maintain the privacy of protected health information and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions please speak to the front desk.

Your signature below is only acknowledgment that you understand that we maintain the privacy of your protected health information. If you would like a formal copy of our Notice of Privacy Practices, please ask for one at the front desk.

Permission to Discuss Medical Information

I give permission for Dr. Bagley and the staff of Bagley Family Dental to discuss my medical/dental information including test results and any treatment to the following family members or friends.

(If this section is left blank, information will only be given directly to the patient. In order for **anyone** to have access to your account ie. Parent, spouse, etc. you must list their name below.)

_____

_____

I agree, this authorization form will remain in effect until a new form is signed.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**