

# WELCOME

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By \_\_\_\_\_

## Thank you for selecting the office of Dr. Mark Freeman & Associates

(All information will be kept strictly confidential)

### Patient Information:

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Home Phone \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_

Spouse / Emergency Contact \_\_\_\_\_

Social Security # \_\_\_\_\_

Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

If College Student, School's Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Year Started \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Email Address \_\_\_\_\_ (Would you like e-mail confirmations?) Yes \_\_\_\_\_ No \_\_\_\_\_

### Responsible Party for Account: (If different from above)

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office? Yes \_\_\_\_\_ No \_\_\_\_\_

### Dental Insurance:

Primary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Payment is expected at time of service.

For your convenience we offer the following methods of payment (please check your preference):

\_\_\_ Cash \_\_\_ Check \_\_\_ Charge Card

\_\_\_ I wish to speak to someone about your payment plans through *Visa* or Dental Fee Plan







# Dental Care Contract

## Dental Care

I hereby authorize the office of Mark Freeman, D.D.S., P.C. and Associates to render dental services to myself (or my child) and to gather and / or release all relative dental and medical information needed to aid in my oral health.

I hereby understand the importance of the appointment times reserved for me (or my child) and understand that:

- 24 hours notice is required to cancel/reschedule an appointment of 1 hour or less
- 48 hour notice is required to cancel/reschedule an appointment of more than 1 hour
- A broken appointment fee of \$15.00 per ½ hour can be charged for any broken appointment or failure to show.

If the Dentist/Hygienist determines I need a dental supply, I understand I have the option to obtain it from the dental office or an outside supplier. If I purchase the supply from the office, I understand full payment is due the day of purchase.

## Insurance

- I hereby authorize the office of Mark Freeman, D.D.S., P.C. and Associates to release any information regarding my claim for dental benefits, and the dental office may, but is not required to, file a claim with my dental insurances.
- I authorize the payment of my insurance benefits be paid directly to Mark Freeman, D.D.S., P.C. and Associates.
- If the insurance company payment is not timely for any reason, I understand it is my responsibility to pay any outstanding bill and pursue recovery or expenses with the insurance company on my own.
- I understand all co-payments and deductibles are due at time of service.
- I understand if I am not insured or if a procedure is not covered by my insurance, payment is due at time of service, unless other payment arrangements have been made.

## Account Billing

- I understand payment is due at time of service.
- Our office accepts cash, personal checks, American Express, Discover Card, Master Card and Visa has payment.
- For those who need extended payment plans, our office participates with CareCredit through GE Capital.
- I understand I am financially responsible for all charges not paid by my insurance and I will pay this balance within 30 days of billing.
- For all minor children brought to this office for treatment, we consider both parents to be financially responsible for all cost incurred in treating your child regardless which parent brings the child to this office. In the case of divorce, both parents will be held responsible until the account is paid.
- If any debt owed to Mark Freeman, D.D.S., P.C. and Associates is referred to their collections attorney, I agree to pay all attorney or collection fees in the amount of thirty percent (30%) of the total indebtedness and court costs incurred by the dental office.

**I have read and understand the above Dental Care Contract and agree to its content for myself and my family.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



## HIPAA AWARENESS FORM

I hereby acknowledge that I am aware that the office of Dr. Mark Freeman D.D.S. and Associates abide by the policies set forth by the Federal Government's HIPAA regulations, and understand that a comprehensive outline of their HIPAA office policies is available to me upon my request.

PATIENT: \_\_\_\_\_

*(Signature of patient / signature of parent)*

DATE: \_\_\_\_\_