PACIFIC CREST DENTAL GROUP
PATIENT INFORMATION FORM

PACIFIC CREST DENTAL GROUP

Patient Name: _____ Date of Birth: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Cell: _____ Work: _____ Other: _____
E-mail: _____Driver's License #: _____ Social Security #: _____
Emergency Contact: _____ Relationship to Patient: _____ Phone: _____
Primary Care Physician: _____ Phone #_____

Insurance Information

Patient Employer: _____ Occupation: _____Work #: _____
Primary Dental Insurance: _____ Phone: _____
Subscriber Name: _____Patients Relationship to Subscriber: _____
ID#: _____ Group#: _____ Group Name: _____
Secondary Dental Insurance: _____ Phone: _____
Subscriber Name: _____Patients Relationship to Subscriber: _____
ID#: _____ Group#: _____ Group Name: _____

Responsible Party

Person Responsible for bill: _____ Home Phone: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Authorization and Release

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such work to third party payers and or health practitioners. I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services, deductibles, and co-insurance. I understand that my insurance carrier may pay less than the actual bill for services. I authorize the physician to release any information required in processing of this claim and all future claims.

I acknowledge that I am financially responsible for the timely payment of my outstanding bill per payment policies I understand that my portion of the balance is due at the time of service. If I do not have insurance the full balance is due at the time of service. The undersigned agrees that unpaid balances over 90 days will receive finance charges of 1 ½ (one and one half) % per month (18%APR). If it becomes necessary to effect collection of any amount owed on this or subsequent visits, the undersigned agrees to pay any and all collection agency fees up to 50% of the amount placed with the collection agency. In the event that legal action must be taken for collections on your accounts, the undersigned will also be responsible for any and all fees associated with court costs, garnishment, and/or attorney fees.

Signed: _____ Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____
_____
_____

Signed:_____

Cancellation Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone and we do our best to accommodate your scheduling needs. When you make an appointment, please be sure that you will be able to keep it. It is our policy that you call as soon as you are aware you may not be able to make an appointment we require at the very least 24 hours' notice.

Like many offices, this office does call, text, and email to confirm your appointment. There will be a charge of $0 for the first, $25 for the second, $50 for the third and $75/possible dismissal for the fourth No Show, broken or cancelled appointments with less than 24 hours' notice. We do understand that sometimes you are unable to give 24 hours' notice and will take each situation in to consideration.

If you find you need to cancel or reschedule an appointment please call 503-581-4615, E-mail office@pacificcrestdental.com, or reply to your confirmation text and we will respond to you as soon as we are in the office to do so.

By signing below, I understand that Pacific Crest Dental Group. requires 24 hours' notice if you I unable to make an appointment and that I will be charged for missing more than one appointment without adequate notice.

Signature: _____ Date: _____