

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr. _____

I wish to be called at: home/ work, other _____ Name of Spouse/Partner _____

Address: 12851 Norfolk Circle
Carmel, IN 46032

Home Phone (____) _____ Work Phone (____) _____ Ext.# _____

Cell (____) _____ E-mail _____

Birthdate _____ Social Security # _____ - _____ - _____

Referred by: Beverly Harrison, DDS Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Name of insured _____

Name of Insured _____

Relationship to Patient _____

Relationship of Patient _____

Insured's Birthdate _____

Insured's Birthdate _____

Soc. Sec. # _____ - _____ - _____

Soc. Sec. # _____ - _____ - _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Insurance Co. _____

Insurance Co. _____

Group # _____

Group # _____

Group Name _____

Group Name _____

_____ I am not covered by any Dental Insurance at this time

I hereby authorize Michael Edwards DDS, MSD, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Michael D. Edwards DDS, MSD of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Michael D. Edwards DDS, MSD.

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: There will be a substantial (1/3 normal fee) charge if a surgical treatment appointment is canceled with less than 3 working days notice. All other appointments require 1 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

Payment: There is a 5% discount for full payment by cash or check at the time services are rendered. We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient or Patient's Legal Guardian

Date_of_Signature