WELCOME TO BAY PEDIATRIC & ADOLESCENT DENTISTRY!

Thank you for taking the time to complete our new patient paperwork. If you have any questions, please just ask.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

ABOUT THE PATIENT(S)

Patient 1's Name: _____
If Applicable, Medicaid #: _____
Patient 2's Name: _____
If Applicable, Medicaid #: _____
Patient 3's Name: _____
If Applicable, Medicaid #: _____
Patient 4's Name: _____
If Applicable, Medicaid #: _____

Pt 1 Likes to Be Called: _____
Male / Female • DOB _____
Pt 2 Likes to Be Called: _____
Male / Female • DOB _____
Pt 3 Likes to Be Called: _____
Male / Female • DOB _____
Pt 4 Likes to Be Called: _____
Male / Female • DOB _____

Patients' Mailing Address: _____ **Email:** _____

INFORMATION RELEASE

I authorize Bay Pediatric & Adolescent Dentistry to release information concerning the patient to those listed below:

_____ Myself/My Voicemail Only _____ Those Listed Below

1. Name: _____ Relationship to Patient: _____ Phone #: _____
2. Name: _____ Relationship to Patient: _____ Phone #: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____
Insured's DOB: _____
Insured's SS #: _____
Insured's Address: _____
(if different from above)

Insured's Employer: _____
Insurance Company: _____
ID #: _____
Group #: _____

GETTING TO KNOW YOU

Who may we thank for referring you? Phonebook • Internet • Bay Pediatric Dentistry Website • ES Parent Mag • Doctor/Dentist/Family/Friend:_____ • Other_____

CONSENT TO ALL OFFICE POLICIES

My signature below indicates the following:

1. I have received, read and understand all new patient paperwork, including but not limited to our financial, treatment, separation and cancellation policies, and the release of certain information under HIPAA. All questions that I may have regarding these policies have been asked and answered to my satisfaction.

2. I understand that patients are strongly encouraged to have regular check-ups, which are typically every six months. At each check-up, I authorize Dr. Hammock and his staff to clean my child's teeth, take diagnostic x-rays and apply fluoride.

3. I agree to the use of certain behavioral management techniques (i.e., nitrous oxide, mouth prop, medical immobilizer) that are deemed necessary by the doctor in order to provide the best and most safe quality of dental care.

4. I understand that it is my responsibility to update this office with any relevant changes to my child's medical history.

5. I understand that a history of missed appointments without adequate notice may result in my child's dismissal as a patient of record.

6. As outlined in the financial policy, I agree to be responsible for payment of all services rendered. I understand that payment is due at the time of service. I understand that if an account balance is incurred, it must be paid in full within 30 days. If payment is not received within that time frame, my account may be turned over to a collections agency, after which, my original balance and any applicable fees will be due.

_____ _____

Print Your Name & Relationship to Patient **Your Signature & Date**

OVER PLEASE