

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.

ABOUT THE PATIENT(S)

Patient 1's Name: _____ If Applicable, Medicaid #: _____	Pt Likes to Be Called: _____ SS #: _____ Male / Female • DOB _____
Patient 2's Name: _____ If Applicable, Medicaid #: _____	Pt Likes to Be Called: _____ SS #: _____ Male / Female • DOB _____
Patient 3's Name: _____ If Applicable, Medicaid #: _____	Pt Likes to Be Called: _____ SS #: _____ Male / Female • DOB _____

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

GETTING TO KNOW YOU

Whom may we thank for referring you? Phonebook • Internet/Website • Rave Theater • Kid City • ES Parent Mag •
Doctor/Dentist/Family/Friend: _____ • Other _____

Does the patient play on a sports team? _____ Would you like information about mouth guards? _____

Is the patient interested in learning about teeth whitening options? _____

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. Additionally, all questions that I may have regarding these policies have been asked and answered to my satisfaction.
2. I hereby authorize Dr. Fellers, Dr. Hammock and staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of the patient's dental needs.
3. Upon such diagnosis, I authorize the doctors and/or staff to perform all recommended treatment.
4. I agree to the use of anesthetics, nitrous oxide and any other behavioral management techniques that are deemed necessary by the doctors to treat the patient with his/her best interests in mind.
5. 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 in the unusual circumstance that an account balance is incurred, it must be paid in full within 30 days. If we have not received payment, your account may be turned over to a collections agency, after which, your original balance and any applicable fees will be due.

Print Your Name & Relationship to Patient

Your Signature

Date