James Hawks, D.D.S., P.C.

•PATIENT INFORMATION

Today's Date:_____

Name:_____
Last First MI

I prefer to be called_____ □Male □Female
Birthdate:_____ Age:_____ SS#_____
□Single □Married □Divorced □Widowed □Separated
Home Address_____

_____
City State Zip
Hm#_____ Cell#_____
□ yes, I would like to receive text reminders for upcoming appointments
Wk #_____Ext#_____
E-Mail_____
□yes, I would like to receive e-mail reminders for upcoming appointments

Responsible Billing Party (if other than above)

_____
Name

_____
Address

_____
City State Zip

Email:_____
Employer:_____
Whom may we thank for referring you?_____
Previous/Present Dentist?_____
Date of last dental visit?_____
What is your primary dental concern?_____

_____

•SPOUSE/PARENT INFORMATION

His/Her Name:_____
Employer:_____
Wk#_____Ext:_____
Cell #_____
Birthdate:_____SS#_____

Emergency Contact
His/Her Name:_____Relation:_____
Wk#_____Hm#_____Cell#_____

•DENTAL INSURANCE

Primary Dental Insurance
Insured's Name:_____Relationship:____
Insured's Birthdate:_____ SS#_____
Insured's Employer:_____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____

Secondary Dental Insurance
Insured's Name:_____Relationship:_____
Insured's Birthdate:_____ SS#_____
Insured's Employer:_____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____

Insurance Authorization

I authorize payment directly to the treating Dr. of all insurance benefits otherwise payable to me. I consent to the use and disclosure of my protected health information to carry out payment and insurance activities for claims made on my behalf. I permit a copy of this authorization to be used in place of the original unless revoked in writing.

Signature:_____

Professional Fees and Billing
Please read our office financial & HIPPA form (in office)

I have received a copy of the Insurance, Financial, and Office Policy document. I understand a 1.5% per month finance charge will be added to outstanding balances aged 90+ days from initial service. I understand I am financially responsible for all services provided. I understand that I will be charged for any checks returned as NSF.

_____
Signature Date

I have read this office's HIPPA and privacy practices policy. (A copy may be requested at this time)

_____
Signature Date