Buffalo Prairie Dental

Quincy@buffaloprairiedental.com Keokuk@buffaloprairiedental.com www.buffaloprairiedental.com

☐ 2801 Broadway Quincy IL 62301 ☐ 3327 Main St Keokuk IA 52632 ☐ 126 N 30th St Quincy IL 62301 (217) 224-7645 / (319) 524-8811 / (217) 228-3384

Welcome to our Practice

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** _____ **Referred By:** _____ *

Email Address: _____ _____

Phone: _____ * _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ * _____
Address 1 Address 2

_____ * * *
City State Zip Code

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

In an emergency who should be notified? Please enter NAME and PHONE NUMBER below: *

How may we communicate with you? (Please check all that apply) *

☐ Contact me at home
☐ Contact me via cell phone
☐ Contact me at work
☐ Contact me via email
☐ Contact me via text message
☐ Leave messages on my home voicemail/answering machine
☐ Leave messages on my cell phone voicemail/answering machine
☐ Leave messages on my work phone voicemail/answering machine

Release of Information

I authorize the following person(s) to have access to information covered under the Privacy Act regarding myself. (Please keep in mind, for us to file with any insurance for you, you must check the "Insurance Company" option)

○ Health Care Providers ○ Insurance Company ○ Other, Specified Below

If "Other, Specified below" is selected please use the space provided:

Responsible Party Information

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: **ID #:** **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Appointment Cancellation and No-Show Policy

Our promise to you: We will respect your time.....we will run on time all day, every day. In return, we ask that you respect our time and the time of our other patients by keeping all appointments that you have scheduled. ***If you no show or cancel any appointment with less than two business days' notice, we will be unable to keep you as a patient and will not schedule any future appointments.***

If you have any questions concerning our appointment policy please feel free to ask us.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.**