New Patient Information Form

Last Name: _____ Title: _____ First Name:_____

Preferred Name: _____

Home Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

I want to receive texts: yes no Gender: M / F

Email address: _____(confirmations and scheduling only)

I am aware in order to hold my appointments I must confirm them either via text/email/phone call. If I fail to confirm my appointments I understand that Dentistry of Newburyport is not required to hold my appointments:_____(initials)

My preferred form on contact for confirmations is:_____

SS#:_____ DOB: _____

Referring Dr: _____ Referring Patient: _____

Cancellation/Rescheduling Policy

As a courtesy our office employs the practice of contacting you prior to your visit to remind you of your scheduled appointments. This system has proven itself extremely effective and reliable, but please be advised that **you are ultimately responsible for keeping the appointments that you make**. We understand that unforeseen events occur which may prevent you from keeping your appointment which is why we have a liberal cancellation policy. If you call us 48 hours prior to the appointment time (and by 5 on Thursday for a Monday appointment) to cancel or reschedule your visit, there will be no charge. However, if we do not hear from you within the acceptable time frame (either to confirm your appointment or to reschedule), then your absence is considered a "no show" or a delinquent cancellation and you will be charged a fee of $50.00.

In no way is it our intention to charge our patients additional money, but please understand the necessity of this policy. It is very costly to us if you miss your appointment and do not give us adequate time to schedule another patient in your time slot. Your dental care is our top priority and **because we value you as a patient, your appointment time has been *solely* reserved for you**. When you do not show up, that time is completely lost. This policy enables us to maintain a high level of service for all our patients.

We greatly appreciate your cooperation in this matter.

"I have read the above statements and verify that I am aware of this office's cancellation/rescheduling policy."

Signature_____ Date_____

Consent for Voicemail/Answering Machine:

I (print)_____ give the office of Dentistry of Newburyport authorization to leave a detailed message at (phone number)_____, and/or (email address) _____ regarding details to an upcoming or previous appointment I had or will have in your office, detailed information regarding a balance I have due, or a credit that I may have to my account until further notice.

Signature: _____ Date: _____

Consent for Treatment/Finances/Appointments

I (print) _____ give the office of Dentistry of Newburyport authorization to discuss my treatment plan, finances or any appointment I have scheduled in your office with the members of my immediate family until further notice.

Signature:_____ Date: _____

Consent for Transfer of Funds Within My Family Account

I (print) _____ give the office of Dentistry of Newburyport authorization to transfer funds within my family's account, giving **credit transfers to balances that may be due at any time, without asking for authorization for each transfer, until further notice.

Signature: _____ Date: _____

**For example, Mom has a credit of -$14 and Daughter has a balance of $9. Dentistry of Newburyport has authorization to transfer $9 from Mom's credit to Daughter's balance.