DENTISTRY
of
NEWBURYPORT

New Patient Information Form

Last Name: _____Title: _____ First Name:_____

Nickname: _____ Preferred method of contact: cell text email

Address: street_____

town_____state_____ zip_____

Home Phone: _____ Cell Phone: _____

Ok with text messages regarding appointments: Y or N

Email address: _____ Gender: M or F

Marital status: Single Married Divorced Widowed

SS#:_____ DOB: _____

Who should we thank for sending you to us?: _____

Cancellation/Rescheduling Policy

As a courtesy our office employs the practice of calling you prior to your visit to remind you of your scheduled appointments. This system has proved 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.

*Office Hours: Monday-Thursday 8am-5pm

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

Signature_____Date_____

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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 family members listed below until further notice.

Family member: _____

Family member:_____

Family member:_____

Family member:_____

Signature:_____Date:_____

Consent for Use and Disclosure of Health and Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE

I, _____, understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.