CAMPBELL STATION
DENTISTRY

**Patient Information**

Patient Name: _____ Patient DOB: _____

Social Security # _____ -_____-_____ Email: _____

Address: _____City_____ State: _____ Zip: _____

Home/Cell Phone : _____ Alternate #: _____

**Emergency Contact Information**

Name: _____ Relationship to Patient: _____ Phone#: _____

**Referral Information**

Whom may we thank for referring you to our practice?

Website__ Facebook __ Instagram __ Another practice _____ Patient _____

**Consent for Services**

I hereby authorize Dr. Wesley Cowan or staff to take necessary x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of above patient.

Upon such diagnosis, I authorize Dr. Wesley Cowan or staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I give consent to the doctor's or designated staff's use and disclose of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

**Financial/Insurance**

I authorize the Practice to submit claims for payment of services rendered or pre-authorizations necessary to my insurance company, on my behalf or on my child's behalf and in my name listed as "signature on file" and assign to Campbell Station Dentistry insurance benefits providing assignment is accepted. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account. I understand that payment is due when services are rendered. I understand that a service charge of 1.5% will be added to any unpaid balances. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/or attorney fees. I understand there will be a $35 fee for any returned checks and no future checks will be accepted for payment.

**CONSENT** - I hereby acknowledge that I have read a copy of this office's informed consent.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN: _____ DATE: _____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES** – I hereby acknowledge that a copy of this offices Notice of Privacy Practices have been made available to me and I have been given the opportunity to ask any questions regarding this Notice.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN: _____ DATE: _____