NEW PATIENT FORM

Magualie J. Woollery, DMD, P.C.
Contemporary Dentistry
7760 Hampton PL| Building 6| Loganville, GA 30052
Phone: (678) 639-0080
http://www.ContemporaryDentistry.com

PATIENT INFORMATION: **DATE:** / /

First Name: _____ **Last Name:** _____ **Middle Initial:**_____

Gender: ▢Male ▢Female **Marital Status:** ▢Single ▢Married ▢Separated ▢Divorced ▢Widowed

SPOUSE's NAME: _____

Birth Date:_____ **Age:**____ **Social Sec #:**_____ **Driver's Lic#**_____ **State:**____

Where should we mail Appointment Reminder Letters and other important health communication?

Address: _____

City: _____ State: _____ Zip: _____

How do we contact you by Phone & Email?

[Primary]_____ [Cell]_____ [Work]_____

Email: _____ ▢ I would like to receive communication by email.

Employment Status: ▢Full Time ▢Part Time ▢Retired **Employer:**_____

Student Status: ▢Full Time ▢Part Time **School:** _____

Patient is also: ▢Responsible Party ▢Primary Insurance Policy Holder

In Case of Emergency Whom Should We Contact?
Name:_____
[Cell] _____ [Email]_____
RELATIONSHIP:_____

Name:_____
[Cell] _____ [Email]_____
RELATIONSHIP:_____

PRIMARY INSURANCE INFORMATION

Name of Insured:_____

Relationship to Insured: ▢Self ▢Spouse ▢Child ▢Other (specify)_____

Insured's Social Security#: _____ **Member ID:**_____

Insured's Date of Birth: _____

Insured's Employer: _____ **GROUP #:**_____

Employer Address: _____

City:_____ **State:** _____ **Zip:**_____

INSURANCE COMPANY: _____**Phone:**_____

Insurance Company Claims Address: _____

City:_____ **State:**_____ **Zip:**_____

If PATIENT is also the RESPONSIBLE PARTY- SKIP this section

RESPONSIBLE PARTY

First Name: _____ **Last Name:** _____ **Middle Initial:**___

Gender: ▢Male ▢Female **Marital Status:** ▢Single ▢Married ▢Separated ▢Divorced ▢Widowed

Birth Date:_____ **Age:**___ **Social Sec #:**_____ **Driver's Lic#**_____ **State:**___

Where should we mail Patient's Account Statements?

Address: _____

City: _____ State: _____ Zip: _____

How do may we contact the responsible party by Phone & Email?
[Primary]_____ [Cell] _____ [Work]_____

EMail: _____

How did you hear about our Office?

(check only one for each question)

Who selected this office? ▢Self ▢Spouse ▢Parent ▢Employer

How did you find the Phone Number to this Office?

▢ Referred by a Friend ▢ Relative ▢ Insurance Plan ▢ Seminar ▢ Postcard in Mail ▢ Direct Mailing

▢ Sign by Building ▢ Health Professional:_____ ▢ Other (specify)_____

If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge _____ (Please initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgement of the doctor decides is necessary to help the patient achieve his/her best health outcome. I also authorize and request the administration of any anesthetics and x-rays as may be judged necessary and advisable by the doctor.

_____

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed_____**DATE**_____

Note: A $100 fee is charged for missed appointments AND appointments cancelled giving less than 24 hours notice.