Welcome

ABOUT YOU

Today's Date:	and the second s	E-mail Address:		
Name:	First Mi	Mr Mrs Ms Dr	d:	☐ Male ☐ Female
	e: Social Security #:		gle 🗆 Married 🗆 Divorced 🗀 Wid	lowed 🗆 Separated
Home Address:				
Home Phone #: ()	Street Cell #: ()	City 	Ext: Driver License #:	Zip
Where & when are best times to	reach you?	_ Whom may we Thank for referring you	n ₅	
Other family members seen by u	us:			
Employer:		How long there?	Occupation:	
Employer's Address:	Street/PO Box	City	State	Zip
	Neighbor o	or Relative not living with you	State	Zip
His / Her Name:	Relation:	Work Phone #: ()	Home Phone #: ()
Address:	Street	City	State	Zip
				Zip
		ble for Account if other than yours		MATERIAL STATE OF THE STATE OF
Name:		Home Phone #: ()		
	Work Phone #: () Ext: D	Privers License #:	
Billing Address:	Street	City	State	Zip
	Oli CCI			
		SE INFORMATION		
His / Her Name:	SPOU	SE INFORMATION	Social Security #:	
	SPOU	SE INFORMATION Birthdate://_		
	SPOU	SE INFORMATION	Ext: Drivers License #:	
	SPOU	SE INFORMATION Birthdate://_	Ext: Drivers License #:	
	SPOU	SE INFORMATION Birthdate:/_/ Work Phone #: () NCE INFORMATION	Ext: Drivers License #:	
Primary Insurance Insurance Co. Name:	INSURA Dental Coverage?	SE INFORMATION Birthdate://_ Work Phone #: () NCE INFORMATION Medical Coverage?	Ext: Drivers License #: Orthodontic Coverage?	Yes No
Primary Insurance Insurance Co. Name:	INSURA Dental Coverage?	SE INFORMATION Birthdate://	Orthodontic Coverage?] Yes
Employer: Primary Insurance	Dental Coverage?	SE INFORMATION	Orthodontic Coverage?] Yes □ No
Primary Insurance Insurance Co. Name: Insurance Co. Address:	Dental Coverage?	SE INFORMATION	Orthodontic Coverage? Up # (Plan, Local or Policy #): State ored's Birthdate:/ Relative	Yes No
Primary Insurance Insurance Co. Name: Insurance Co. Address: Insured's Name:	Dental Coverage?	Birthdate:// Work Phone #: () NCE INFORMATION Medical Coverage? Yes No e #: () Grounds City Security #: Insures: Street/PO Box	Orthodontic Coverage? Up # (Plan, Local or Policy #): State Orthodontic Coverage? Drivers License #:	Yes □ No Zip tion: Zip
Primary Insurance Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Employer: Secondary Insurance	Dental Coverage?	Birthdate:/ Work Phone #: () NCE INFORMATION Medical Coverage?	Orthodontic Coverage? Up # (Plan, Local or Policy #): Orthodontic Coverage? City State Orthodontic Coverage?	Yes No Zip Zip Zip
Primary Insurance Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Employer: Secondary Insurance Insurance Co. Name:	Dental Coverage?	Birthdate:/ Work Phone #: () NCE INFORMATION Medical Coverage?	Orthodontic Coverage? Up # (Plan, Local or Policy #): State Orthodontic Coverage? Drivers License #:	Yes No Zip Zip Zip
Primary Insurance Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Employer: Secondary Insurance Insurance Co. Name: Insurance Co. Address:	Dental Coverage?	Birthdate:/ Work Phone #: () NCE INFORMATION Medical Coverage?	Orthodontic Coverage? Up # (Plan, Local or Policy #): Orthodontic Coverage? City State Orthodontic Coverage? Up # (Plan, Local or Policy #): State	Yes No Zip Zip Yes No
Primary Insurance Insurance Co. Name: Insured's Name: Insured's Employer: Secondary Insurance Insurance Co. Name: Insurance Co. Name: Insurance Co. Address: Insurance Co. Address:	Dental Coverage?	SE INFORMATION	Orthodontic Coverage? Orthodontic Coverage? Orthodontic State Orthodontic Coverage? Orthodontic Coverage? Orthodontic Coverage? Orthodontic Coverage? State Orthodontic Coverage?	Yes □ No Zip Ition: Zip Yes □ No
Primary Insurance Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Employer: Secondary Insurance Insurance Co. Name: Insurance Co. Address:	Dental Coverage?	SE INFORMATION	Orthodontic Coverage? Up # (Plan, Local or Policy #): Orthodontic Coverage? City State Orthodontic Coverage? Up # (Plan, Local or Policy #): State	Yes No Zip Zip Yes No

Rebecca L. Forrest, D.D.S,PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

l,		, have received a copy of this office's Notice of	
Privac	cy Practi	ces.	
	{Pleas	e Print Name}	
	{Signa	ature}	
	{Date}		
		For Office Hos Only	
		For Office Use Only	
		I to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but ment could not be obtained because:	
		Individual refused to sign	
		Communications barriers prohibited obtaining the acknowledgement	
		An emergency situation prevented us from obtaining acknowledgement	
		Other (Please Specify)	

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ASSIGNMENT AND RELEASE/FINANCIAL AGREEMENT

Date	_
Patient Name	
ASSIGNMENT AN	ND RELEASE
I, the undersigned, have	insurance with
	Name of Insurance Company(ies)
for services rendered. I whether or not paid by i necessary to secure the	Dr. Rebecca Forrest all benefits, if any, otherwise payable to me understand that I am financially responsible for all charges nsurance. I hereby authorize the doctor to release all information payment of benefits. I authorize the use of this signature on all my whether manual or electronic.
Date	Patient Signature
FINANCIAL AGR	EEMENT
made. I agree that parent treatment of a minor/chiby insurance. I understate collection agency. I agree be based on a percentage	ment is due at the time of treatment, unless other arrangements are ts/guardians are responsible for all feeds and services rendered for ild. I accept full financial responsibility for all charges not covered and that if the account is not paid in full, it will be turned over to a see to reimburse you the fees of any collection agency, which may e at a maximum of 33% of the debt, and all costs, and expenses, orneys' fees, we incur in such collection efforts.
Date	Signature of Insured/Guardian