# Welcome

## ABOUT YOU

Today's Date: _____ E-mail Address: _____

**Name:** _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

**Home Address:** _____
Street City State Zip

Home Phone #: (_____)_____ Cell #: (_____)_____ Work Phone #: (_____)_____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

### Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

### Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (_____)_____ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: _____ Drivers License #: _____

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

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

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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)

_____

_____

_____

# ASSIGNMENT AND RELEASE/FINANCIAL AGREEMENT

_____
Date

_____
Patient Name

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with

_____
*Name of Insurance Company(ies)*

and assigned directly to Dr. Rebecca Forrest all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Patient Signature

## FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all feeds and services rendered for treatment of a minor/child. I accept full financial responsbility for all charges not covered by insurance. I understand that if the account is not paid in full, it will be turned over to a collection agency. I agree to reimburse you the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

_____ _____
Date Signature of Insured/Guardian