

# WELCOME TO BAY PEDIATRIC & ADOLESCENT DENTISTRY!

Thank you for taking the time to complete our new patient paperwork. If you have any questions, please just ask.

## ABOUT THE PATIENT(S)

<b>Patient 1's Name:</b> _____ If Applicable, Medicaid #: _____	<b>Pt 1 Likes to Be Called:</b> _____ Male / Female • DOB _____
<b>Patient 2's Name:</b> _____ If Applicable, Medicaid #: _____	<b>Pt 2 Likes to Be Called:</b> _____ Male / Female • DOB _____
<b>Patient 3's Name:</b> _____ If Applicable, Medicaid #: _____	<b>Pt 3 Likes to Be Called:</b> _____ Male / Female • DOB _____
<b>Patient 4's Name:</b> _____ If Applicable, Medicaid #: _____	<b>Pt 4 Likes to Be Called:</b> _____ Male / Female • DOB _____
<b>Patients' Mailing Address:</b> _____ <b>Email:</b> _____	

## INFORMATION RELEASE

I authorize Bay Pediatric & Adolescent Dentistry to release information concerning the patient to those listed below:  
\_\_\_\_\_ Myself/My Voicemail Only \_\_\_\_\_ Those Listed Below

1. Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Name of Insured: _____	Insured's Employer: _____
Insured's DOB: _____	Insurance Company: _____
Insured's SS #: _____	ID #: _____
Insured's Address: _____ <i>(if different from above)</i>	Group #: _____

## GETTING TO KNOW YOU

Whom may we thank for referring you? Phonebook • Internet • Bay Pediatric Dentistry Website • ES Parent Mag •  
Doctor/Dentist/Family/Friend: \_\_\_\_\_ • Other \_\_\_\_\_

## CONSENT TO ALL OFFICE POLICIES

*My signature below indicates the following:*

1. I have received, read and understand all new patient paperwork, including but not limited to our financial, treatment, "separation" and cancellation policies, and the release of certain information under HIPAA. Additionally, all questions that I may have regarding these policies have been asked and answered to my satisfaction.
2. I hereby authorize Dr. Hammock and staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. Upon such diagnosis, I authorize the doctor and/or staff to perform all recommended treatment.
4. I agree to the use of anesthetics, nitrous oxide and any other behavioral management techniques that are deemed necessary by the doctor in order to provide the very best quality of dental care.
5. As outlined in the financial policy, I agree to be responsible for payment of all services rendered. I understand that payment is due at the time of service. I understand that if an account balance is incurred, it must be paid in full within 30 days. If we have not received payment within that timeframe, your account may be turned over to a collections agency, after which, your original balance and any applicable fees will be due.

\_\_\_\_\_ **Print Your Name & Relationship to Patient**

\_\_\_\_\_ **Your Signature**

\_\_\_\_\_ **Date**  
**OVER PLEASE**