FINANCIAL INFORMATION

If you do not have dental insurance, full payment is expected for each visit. Please circle how you prefer to pay: cash check credit card care credit

If you have dental insurance, please fill in the information below so we can complete and submit the insurance claims for you.

Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Phone #: ______________________

Group # __________ Policy ID#: ______________

Insured's Name ______________ Relation: __________

Insured's SS# ______________ D.O.B. ____/____/____

Insured's Employer: ______________________

Secondary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Phone #: ______________________

Group # __________ Policy ID#: ______________

Insured's Name ______________ Relation: __________

Insured's SS# ______________ D.O.B. ____/____/____

Insured's Employer: ______________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent:

Name: ____

Address: ______________________________ City: ______________ State: ________ Zip: ____

Home Phone: ______________ Work Phone: __________ Cell Phone: __________ Email: ______________

To the Patient – Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those Changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by call our office at: 315-635-3671

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office, addressed to David R. Pearce, DDS, PC. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I, (print name)______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: ______________________________ Date: ______________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________