Gentle Dentistry of Columbus, P.C.
Darcy R. Leerssen, D.D.S. Jeffery A. King, D.M.D.

1846 WARM SPRINGS ROAD | COLUMBUS, GEORGIA 31904 | OFFICE: 706-322-6551

PERSONAL INFORMATION

PANO DATE: _____

Mr. Mrs. Ms. Dr. Today's Date: _____

Name_____ Preferred Name _____

DOB _____Age_____ SSN_____ Male/Female

Address_____

Home Phone_____ Cell Phone _____

Email _____

Employer Name_____ Business Phone _____

Preferred Method of Notification: Home Phone Cell Phone Business Phone Text Email
Please circle all that apply.

PARENT/SPOUSE INFORMATION

Name _____ (Home/Cell) _____

Address _____

Employer Name _____ Business Phone _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

Address _____

INSURANCE INFORMATION

PRIMARY Insurance Co. Name_____ Name of Insured _____

Insured SSN _____DOB _____

SECONDARY Insurance Co. Name_____ Name of Insured_____

Insured SSN _____DOB _____

REFERRED BY: _____

To the best of my knowledge the above confidential information is true. If the above named patient is a minor, I also give my permission for treatment.
SIGNED: _____

NOTICE OF PRIVACY PRACTICES

Please be advised that our office continues to maintain the confidentiality of each patient's personal and health information. The information you provide to this office will only be used to provide quality dental care, for billing requirements and for routine healthcare operation.
I acknowledge reading the Notice of Privacy practices for this office. By signing this consent I authorize this office to use and disclose as necessary my protected information.

Relationship to Patient: _____ Signature: _____

FINANCIAL INFORMATON

I understand that the charges of this account remain the responsibility of the person signing this form, either: the Patient, Guarantor, Parent, Guardian or accompanying adult.

* **AS A SERVICE TO YOU AND/OR YOUR FAMILY, OUR OFFICE, GENTLE DENTISTRY OF COLUMBUS, P.C., WILL FILE YOUR DENTAL INSURANCE BENEFITS. HOWEVER, PLEASE REMEMBER THAT INSURANCE IS NOT A GURANTEE OF PAYMENT AND IS NOT TO BE CONSIDERED AS A TOTAL METHOD OF PAYMENT FOR OUR SERVICES. THE PATIENT/GUARANTOR IS REPONSIBLE TO PAY ANY DEDUCTIBLES OR PATIENT ESTIMATED PORTIONS AT THE TIME OF SERVICE.**
* IF FOR ANY REASON THE INSURANCE COMPANY DOES NOT PAY, I (THE UNERSIGNED) ASSUME **FULL RESPONSIBILTY** OF THE UNPAID CHARGES. IF THE INSURANCE COMPANY DOES NOT PAY BENEFITS WITHIN **60 DAYS** FROM OUR FILING DATE, THE GUARANTOR WILL BECOME RESPONSIBLE FOR THE OUTSTANDING BALANCE.
* PRICES, FEES OR BENEFITS QUOTED IN OUR OFFICE ARE ESTIMATES ONLY. FINAL CHARGES OR BENEFITS PAID BY THE INSURANCE COMPANY WILL BE BASED ON WORK PERFORMED AND CLAIMS FILED AFTER WORK HAS BEEN COMPLETED.

I understand that if a check I have written for dental treatment is returned by the bank for non-sufficient funds there will be a Returned Check Fee of $35.
I understand that unpaid balances may be subject to 1.50% (APR 18.00%) Monthly Finance Charge.
If this account becomes past due and is assigned to an attorney or collection agent,
Gentle Dentistry of Columbus, P.C. is entitled to all reasonable attorney's fees and/or costs of collections.

The undersigned agrees, whether signed as Agent, Guarantor, or Patient that in consideration of the services to be rendered to the Patient, the Patient hereby individually obligates himself to pay the amount of the account to this office in full or other satisfactory financial arrangements must be made prior to time of Patient services. Further, should it become necessary to enforce collection of the account, the undersigned(s) singularly and jointly agrees to all such collection expense. All delinquent accounts bear interest charges at the highest legal rate. Further, the undersigned (s) agree to pay 15% attorney fees if the account is collected by or through an attorney at law.

* I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any Insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Gentle Dentistry of Columbus, P.C. This Assignment will remain in effect until revoked by me in writing; a photocopy of this Assignment is to be considered as valid as an original.

I fully agree to the Financial Responsibilities and Assignment of Insurance Benefits* as stated above.
YOU SHOULD READ THESE TERMS CAREFULLY.

Signature: _____ Printed Name: _____ Date: _____

*If you do not have Dental Insurance and we are not filing for your benefits, these statements will not apply to your account.