Paige Prather Smiles
doctorpaige.com
office@paigeprathersmiles.com
3326 Aspen Grove Drive | Suite 120 • Franklin, TN 37067 (615)771-2151

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-____* (Zip Code)

In case of emergency, who is to be notified? (Please provide best contact phone number)

_____

_____

Please verify that the information you have provided is correct.

☐ **By checking this box, I understand that I will be given a medical claim form to submit indivdually to my medical insurance company to seek any reimbursement.**

Minor/Child Agreement:

☐ **I understand that any parent, who brings in a minor for treatment, is responsible for that patient's account balance. A Guardian must remain in the office for the entire duration of a minor's treatment. No patient, under the age of 18, will be treated without a documented guardian present in the office. I verify that I am the parent/guardian of the said patient and there are no court orders now in effect that prohibit me from signing this form. I do hereby authorize the dental staff of Dr. Paige Prather to perform any necessary dental services for the stated minor. Should a child be "dropped off" or left without an attending guardian, the dependent's appointment will be cancelled and charges will apply.**

Cancellation Policy

☐ * **Your appointment time is especially reserved for you. We value your time and we ask that you value the time of our doctor and other patients. Having an accurate schedule allows our team to provide each patient with maximum attention and allows us to keep more closely to your scheduled appointment time. We pride ourselves on little to no wait time. A $75 cancellation fee will be applied for any appointment 1 hr. or less in length canceled without 2 business days notice. Down payments are required to schedule any appointment over 1 hour in length. These down payments are nonrefundable if cancelled without 2 business days notice. Cancellation of a sedation appointment will differ from this basic policy and these terms will be reviewed at the time of booking the appointment. If you arrive more than 20 minutes late you will be asked to reschedule your appt. out of consideration for our other patients' time and a cancellation fee will apply. If you cancel more than 2 times without 2 business days notice within a period of 6 months, you will be moved to our Priority Scheduling list, meaning appointments cannot be scheduled more than one day in advance of the appointment time. We provide complimentary reminders of your appointment via text, email, and phone calls. Most of our patients greatly appreciate this service. You may choose the reminder method that works best for you or opt out of this service entirely. However, all cancellation policies still apply. If you have questions or concerns about this policy, please consult with a team member prior to scheduling an appointment.**

Financial Policy: Please read over thoroughly prior to receiving services.

☐ * **Payment is due, in full, at the time of service. We can accept Cash, Mastercard, Visa, Discover, American Express, Care Credit and insurance checks. We accept personal checks from patients with a record of 6 months with our practice. We charge a service fee of $30.00 for any check that is returned.**

☐ * **HIPAA NOTICE: Notice of Privacy Practices: Effective Date of Notice: January 24, 2007. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. This Notice is available at any time, for your review or personal copy, in the reception area of our practice. By checking this box you are confirming knowledge of your rights to privacy as a patient and the receipt of this Notice.**

☐ * **By checking this box, I acknowledge that the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor have any changes in contact/personal information. I realize that failure to do so can result in inability to reach me and or provide products and or notifications reguarding my treatment and health and that additional costs may be incured because of this.**

Please sign and date below:

Signature _____ **Date** _____

Response Date:
____/____/_____