Dental Art Designs
Juana Geldres, DDS, PA.

2023

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2023 PATIENT INFORMATION

Date: _____

Patient's Name: _____ DOB :_____

Address: _____City: _____State: _____ Zip Code: _____

Email: _____@_____

SS# _____ (Required for Insurance)

Work Phone: _____ Cell Phone: _____ Home Phone: _____

INFORMATION OF RESPONSIBLE PERSON

If any other than the Patient: Relationship to Minor/Patient:_____

Patient's Name: _____ Date _____

Address: _____City: _____ State: _____ Zip Code: _____

SS # _____ DOB: _____ Cell Phone: _____

HIPPA

I have reviewed the **Notice of Privacy Practices** and a copy will be provided upon request.

MEDICAL HISTORY

____ My Medical History hasn't changed since my last visit.

____ My Medical History has changed since my last visit. If yes, the office will need an updated Medical History Form.

FINANCIAL POLICY

I have reviewed the **Financial Policy** of the office and acknowledge there is a signed copy on file.

After reading and understanding, I request that services to be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make a payment when due and my account becomes delinquent it will be turned over to a collection agency. I am fully responsible to pay all collections costs and processing fees that may apply. I will also be at risk to be dismissed from the practice as a patient.

I have read this Financial Policy as outlined and understand that I am ultimately responsible for the charges incurred by my child/children as their legal guardian.

I certify the above information is correct and true to the best of my knowledge. Date:_____

Guardian/Parent Name (if minor): _____

Guardian/Parent Signature: _____

Patient Signature: _____