Indigo DENTAL
Family-Cosmetic-Sedation

Welcome to Our Office

Personal

Date _____ Patient Name _____
Address _____
Phone _____ Email _____
Sex M____ F____ Birth Date _____ Marital Status _____
SSN _____ When was your last dental visit _____

What brings you to us today
_____
_____
What is your preferred method to confirm your appointment Text/Email/Phone

How did you hear about us _____
Is there someone we can thank for your referral _____

Emergency Contact
Name_____ Relationship _____ Phone _____

Insurance

Primary Subscriber's Name _____ Their Birth Date _____
Their SSN _____ Relationship to Patient _____
Insurance Company _____ Employer _____
ID Number _____ Group Number _____

Secondary Insurance

Primary Subscriber's Name _____ Their Birth Date _____
Their SSN _____ Relationship to Patient _____
Insurance Company _____ Employer _____
ID Number _____ Group Number _____

Consent for Services and Financial Policy

Indigo Dental is glad to accept your insurance and file it as a courtesy to you. When we provide you with a treatment plan for services, we are basing these fees on the information that we have received from your insurance company. Although we make every effort to ensure that these are inclusive and correct, there is a possibility that your insurance company may pay differently on a service. We have no control over this. If there is any unpaid portion of your claims, it is the responsibility of the patient to pay the uncovered balance. If you are an uninsured patient we do expect payment at the time of services unless you have a prior arrangement with the financial office.The balance on the account is due within 30 days of services. If you do not take care of the balance, we will have to utilize the resources of an outside collection agency.

Missed Appointment Agreement

It is our policy for you to give us 48 hours notice if you need to change an appointment, please call and speak directly with a staff member as our answering machine does not accept changes or cancellations. We have several avenues to verify our patients' appointments; we ask that you make sure to confirm your appointments in order to reserve your appointment time. There will be no penalty for the first missed appointment as a courtesy. However, any subsequent missed appointment will then require a 50% deposit to reschedule. Any sedation appointment or appointment requiring over 2 hours will require a 50% deposit to schedule.

Privacy Notice

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time this authorization may be revoked when the office that receives this authorization receives a written revocation. The revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I give Indigo Dental permission to take photos and videos for marketing use Y ____ N____

I understand that Indigo Dental has permission to call the number(s) I have provided and permission to leave voicemails regarding my appointment/medical information Y ____ N ____

I release all medical information to the following people/medical offices _____

_____

Indigo DENTAL
Family-Cosmetic-Sedation

Signature _____

Date _____