DENTAL CARE ASSOCIATES
OF WAYCROSS *Our focus is your smile*

Welcome to our practice! To prepare for your first visit with us, please complete the following forms and bring them to your appointment. You may also fax them in advance if you prefer, 912.285.0762.

Also, a few things to remember:

- Please arrive 10 minutes early so we can complete your registration and see you at your scheduled appointment time.

- If you need to reschedule your appointment, please contact us at 912.285.5967 at least 24 hours in advance, so we can serve other patients needing dental care.

- Please bring your photo identification, insurance cards and an updated list of any medications you may be taking to your appointment.

- Co-payments, deductibles and balances owed are due at the time of service. We accept cash, checks, credit cards and CareCredit healthcare financing.

Thank you for choosing Dental Associates of Waycross as your new dental home. We look forward to meeting you!

Sincerely,

The Dental Care Associates of Waycross Team

1601 B Alice Street, Waycross, GA 31501 · Phone 912.285.5967 Fax 912.285.0762

Dental Care Associates of Waycross

1601 B Alice Street • Waycross, GA 31501 • (912) 285-5967

PATIENT NUMBER

REGISTRATION

Today's Date _____ Age _____

Patient's Name _____ Date of Birth Male ❑ Female ❑

If Child: Parent's Name _____

How do you wish to be addressed _____

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed ❑Minor

Residence-Street _____

City _____ State _____ Zip _____

Phone Home _____ Work _____

Cell _____

Email _____

Social Security # _____

Employer _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Address/Phone _____

Drivers License No _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Emergency Contact Name & Number _____

DENTAL INSURANCE FIRST COVERAGE

Employee Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____ Yrs _____

Name of Insurance Co _____

Address _____

Phone _____

Program/Policy # _____

Social Security # _____

Union Local or Group _____

DENTAL INSURANCE SECOND COVERAGE

Employee Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____ Yrs _____

Name of Insurance Co _____

Address _____

Phone _____

Program/Policy # _____

Social Security # _____

Union Local or Group _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentists use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement I revoke all previous agreement to the contrary and agreed to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

PATIENT INFO

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, acknowledge that I have received a Notice of Privacy Practices from Dental Care Associates of Waycross.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT FOR OFFICE USE ONLY

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

SIGNATURE

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.