BROOKWOOD
DENTISTRY

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. Any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask.
To safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

PATIENT INFORMATION

Patient’s Name ____________ Birthdate ________ Sex ______ SS# ____________

Address ____________________________

City ____________ State ________ Zip ________ Marital Status ________

Home Phone ________ Cell Phone ____________ Work Phone ____________

Employer Name ________ Occupation ________ Email Address ____________

Whom may we thank for recommending us? ____________________

SPOUSE OR PARENT INFORMATION

Spouse / Parent Name ____________ Birthdate ________ SS# ____________

Employer Name ____________ Occupation ____________ Work Phone ________

Names of Children / Parents ____________________

INSURANCE INFORMATION

Policy Holder ____________ Birthdate ________ Employer ____________

Insurance Company ____________ Group# ________ ID# ____________

Insurance Telephone # ____________

Address ____________ City ________ State ______ Zip code ________

Name and phone number of the nearest relative (not living with you) ____________

For your convenience we can accept VISA or Master Card, Discover and American Express.

All fees for professional services are due and payable at the time of treatment. If you have insurance, as a courtesy, we will file a claim to your PRIMARY INSURANCE ONLY. We require that you pay your estimated portion when services are rendered and any unpaid balance that your insurance does not pay for after forty-five days. After that time a rebilling fee may apply. The patient (parent or guardian) will be held liable for attorney’s fees of 15% of the balance due if unpaid after 90 days.
Please be advised that 48-hour notice is required to change an appointment. Last minute cancellations are subject to a broken appointment fee. Thank you for your cooperation in this matter.

I acknowledge and agree that payment for services rendered is due at the time that such service is rendered and that payment arrangements must be made in accordance with the terms of the financial policy. I authorize payment of benefits to Dr. Brandon L. Esco for services rendered under the terms of my insurance policy. I authorize Dr. Brandon L. Esco to release any dental information or other information necessary to process insurance claims.

Signature ____________________ Date ________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

We must provide this notice to each patient no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-Faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also make the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time-of-service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

I, ____, have received a copy of this office's Notice of Privacy Practices. (Please Print Name)

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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