Welcome to Walker Dentistry p.c.

10177 Allisonville Rd. • Suite 101 • Fishers, IN 46038 • (317) 849-8550

HOW DID YOU HEAR ABOUT OUR OFFICE? _____
(PERSON OR OTHER)

HAVE ANY OTHER FAMILY MEMBERS BEEN SEEN AT OUR OFFICE? _____
(PERSON)

TODAY'S DATE _____

PATIENT

NAME _____
LAST FIRST MIDDLE

SOCIAL SECURITY # _____ SEX M ☐ F ☐

BIRTHDATE _____ MARITAL STATUS _____

ADDRESS _____
STREET

ADDRESS _____
CITY STATE ZIP CODE

EMAIL ADDRESS _____

Please indicate which numbers below would be acceptable to reach you in person for appointment confirmation during business hours.

☐ **HM# ( )**_____ ☐ **WK# ( )** _____

☐ **CELL# ( )**_____ ☐ **PAGER# ( )**_____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____
CITY STATE ZIP CODE

SPOUSE ☐ OR PARENT OF MINOR ☐

NAME _____
LAST FIRST MIDDLE

SOCIAL SECURITY # _____ SEX M ☐ F ☐

BIRTHDATE _____ MARITAL STATUS _____

ADDRESS _____
STREET

ADDRESS _____
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EMPLOYER _____

EMPLOYER ADDRESS _____

_____
CITY STATE ZIP CODE

Emergency Contact Information

Name _____ Home Phone _____

Work Phone _____ Cell Phone _____ Relationship _____

FINANCIAL ARRANGEMENTS

PAYMENT IS DUE IN FULL AT EACH APPOINTMENT.
For your convenience, we accept cash, check, or credit. Payment plans may be available.

I wish to discuss payment plan options. ☐

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER INSURANCE BENEFITS. I ALSO AGREE TO PAY ALL FINANCE CHARGES, COLLECTION AGENCY FEES, ATTORNEY FEES, COURT COSTS OR ANY OTHER FEES INCURRED BY WALKER DENTISTRY FOR THE PURPOSE OF COLLECTING A DEBT I OWE.

I authorize payment of medical benefits to the names provided for professional services rendered.
I authorize the release of any medical information necessary to process an insurance claim, or to exchange information with another medical professional.

Signature X _____ **Date** _____
Patient or parent, if minor

PLEASE COMPLETE BACKSIDE

Patient Consent

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment.
- Obtain payment from third-party payers.
- Present case presentations for educational and/or marketing purposes with de-identified Protected Health Information.
- Conduct normal healthcare operations such as quality assessments and physical certifications.
- Release my records to another office if I request it.

I have been informed by you and your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, education and/or marketing purposes, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient: _____

Signature **X**_____ Date: _____

Cancellation Policy

Walker Dentistry requires a 48 Hour notice to cancel an appointment. If proper notice is not given a service charge will be applied to your account. If the appointment is rescheduled at the time of cancellation and the new appointment is kept, the service charge will then be waived.

I understand the 48 hour cancellation policy

Signature **X**_____