DENTAL INSURANCE INFORMATION

PRIMARY
EMPLOYER_____
Subscriber: _____
Subscriber Birthdate: _____
ID/SSN _____ _
Company: _____

SECONDARY
EMPLOYER_____
SUBSCRIBER: _____
Subscriber Birthdate: _____
ID/SSN _____
Company: _____

Cancellation Policy: We require at least 24 hours notice to cancel an appointment or you will incur a $50 late notice fee. The fee will also apply to missed appointments. INITIAL:_____

PHOTO RELEASE: I _____the undersigned do hereby authorize and consent to the use of photographs/x-rays of me taken by [Scheier & Price Family Dentistry]. I do consent to the use of my photographs or images for marketing materials including website, social media and patient education for (Scheier & Price Family Dentistry) only.

Patient's Name: _____

Patient or Guardian Signature: _____ Date: _____

HIPAA: I have reviewed or received a copy of this office's Notice of Privacy Practices.
Print Name: _____Date: _____
SIGNATURE (Parent/Guardian signature for minor): _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:
Relationship to Patient _____

I give permission for Scheier Family Dentistry to discuss treatment,
Pre-authorization and account with: _____
Relationship to Patient:_____

Signature_____Date_____