New Patient Information Form

Last Name: ____________________ Title: _____ First Name:________________

Preferred Name: _____________________

Home Address: ____

City/State/Zip Code: ____

Home Phone: ________________________ Cell Phone: _____________________

I want to receive texts: yes no Gender: M / F

Email address: _________________________________(confirmations and scheduling only)

SS#:____________________________ DOB: ___________________________

Referring Dr: ___________________ Referring Patient: ____________________

Cancellation/Rescheduling Policy

As a courtesy our office employs the practice of calling you prior to your visit to remind you of your scheduled appointments. This system has proved itself extremely effective and reliable, but please be advised that **you are ultimately responsible for keeping the appointments that you make**. We understand that unforeseen events occur which may prevent you from keeping your appointment which is why we have a liberal cancellation policy. If you call us *48 hours prior to the appointment time (and by 5 on Thursday for a Monday appointment) to cancel or reschedule your visit, there will be no charge. However, if we do not hear from you within the acceptable time frame (either to confirm your appointment or to reschedule), then your absence is considered a "no show" or a delinquent cancellation and you will be charged a fee of $50.00.

<u>In no way is it our intention to charge our patients additional money</u>, but please understand the necessity of this policy. It is very costly to us if you miss your appointment and do not give us adequate time to schedule another patient in your time slot. Your dental care is our top priority and **because we value you as a patient, your appointment time has been *solely* reserved for you**. When you do not show up, that time is completely lost. This policy enables us to maintain a high level of service for all our patients.

We greatly appreciate your cooperation in this matter.

*Office Hours: Monday-Thursday 8am-5pm

"I have read the above statements and verify that I am aware of this office's cancellation/rescheduling policy."

Signature____ Date_________________

Consent for Voicemail/Answering Machine:

I (print)___________________________ give the office of Kuljic DDS & Team

authorization to leave a detailed message at (phone number)___________________, and/or

(email address) _____________________________ regarding details to an upcoming or previous

appointment I had or will have in your office, detailed information regarding a balance I have

due, or a credit that I may have to my account until further notice.

Signature: ____________________________ Date: ____________________________

Consent for Treatment/Finances/Appointments

I (print) ___________________________ give the office of Kuljic DDS & Team

authorization to discuss my treatment plan, finances or any appointment I have scheduled

in your office with the members of my immediate family until further notice.

Signature:_______________________________ Date: ___________________________

Consent for Transfer of Funds Within My Family Account

I (print) __________________________ give the office of Kuljic DDS & Team

authorization to transfer funds within my family's account, giving **credit transfers to

balances that may be due at any time, without asking for authorization for each transfer,

until further notice.

Signature: _______________________________ Date: ___________________________

**For example, Mom has a credit of $14 and Daughter has a balance of $9. Kuljic DDS & Team has authorization to transfer $9 from Mom's credit to Daughter's balance.