Harelick Dental
Associates of Holliston, LLC

PATIENT'S NAME: ……PREFERRED NAME: ...……..

ADDRESS:…….... CITY:…… STATE: …….ZIP: ……..

DATE OF BIRTH: ……/……/……SOCIAL SECURITY NO: ……..

❑ MALE ❑ SINGLE ❑ FEMALE

❑ MARRIED ❑ WIDOWED ❑ MINOR

HOME #:……..……...CELL #: ……WORK #: ……..……

EMAIL ADDRESS: ……...

WHAT IS YOUR PREFERRED MEANS OF COMMUNICATION? ❑HOME ❑CELL ❑WORK ❑EMAIL

HAVE ANY MEMBERS OF YOUR FAMILY PREVIOUSLY VISITED OUR OFFICE?.....

EMERGENCY CONTACT: ……..……..RELATIONSHIP: ……

PHONE #:…….……ALTERNATE # (IF AVAILABLE): ……..

HOW DID YOU HEAR ABOUT OUR OFFICE? ……..

WE WOULD BE PLEASED TO HELP YOU IN THE FILING OF YOUR DENTAL INSURANCE CLAIMS. WE ACCEPT DIRECT PAYMENT FROM MOST INSURANCE COMPANIES. BASED ON THE INFORMATION THAT WE ARE ABLE TO OBTAIN REGARDING YOUR SPECIFIC DENTAL BENEFITS, WE WILL DO OUR BEST TO PROVIDE AN ESTIMATE OF THE INSURANCE COMPANY'S EXPECTED CONTRIBUTION TOWARDS YOUR VISITS TO OUR OFFICE. IF THERE IS A CHANGE IN YOUR DENTAL BENEFITS, PLEASE UPDATE OUR OFFICE WITH THE NEW INFORMATION.

PRIMARY DENTAL INSURANCE COMPANY: ……
SUBSCRIBER'S NAME: ……RELATIONSHIP: ……..
DATE OF BIRTH: ……/……/…… SOCIAL SECURITY OR SUBSCRIBER ID#: ……..
GROUP OR EMPLOYER NAME:……GROUP # ……..

SECONDARY DENTAL INSURANCE COMPANY:……
SUBSCRIBER'S NAME: …… RELATIONSHIP:……...
DATE OF BIRTH: ……/……/…… SOCIAL SECURITY OR SUBSCRIBER ID#: ……..
GROUP OR EMPLOYER NAME: ……..GROUP #.....

Payment in full, excluding any amount expected from the insurance company is due at the time of service. We accept cash, check, credit cards and an extended payment plan option through an outside financing company. Please let us know if you would like our assistance in arranging for this outside financing. Please note, the amount expected from the insurance company is an estimate. We will make adjustments to your account as the claims come back and credit or bill you accordingly.

Your appointment time is reserved specifically for you. While emergencies happen and procedures can take longer than expected, we respect that your time is valuable and we will make every effort to see you at the time scheduled. We appreciate the same courtesy from our patients and request that you give at least 48 hours notice if you need to change or cancel an appointment. Failure to keep scheduled appointments, without adequate notice, may result in a fee.

I authorize and request the performance of dental services for myself or my minor child, and give my consent to any advisable dental procedure, medication or anesthetic to be administered by Dr. Natalie Harelick, Dr. Scott Harelick or their staff, as well as, the use of my photographs and x-rays for the purpose of education or presentation. I also give permission to contact my physicians, dentists or dental specialists for any necessary medical/dental information pertaining to my treatment needs. I also authorize information to be released to insurance companies and that payment be made directly to Harelick Dental Associates of Holliston from insurance companies for benefits otherwise payable to me.

I understand that any balance remaining unpaid after a period of 30 days may be subject to a 1.5% service charge or a minimum service charge of $3. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collections costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or Guardian's Signature: ……..Date:……..

I, ……., have received a copy of the Notice of Privacy Practices and understand that my protected health and personal information will only be used to carry out treatment, payment activities, healthcare operations and insurance benefits. I understand my right to refuse to sign or to revoke this consent, at any time, in accordance with the guidelines in the Notice.

Patient or Guardian's Signature: ……..Date:……..