Ferguson Family Dentistry

8670 Ferry St, Montague, MI 49437 · (231) 894-4820

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Marital Status: M ☐ S ☐ D ☐ W ☐ Under 18 ☐ Driver's License # _____

Male ☐ Female ☐ Email Address: _____ DOB: _____ SS#: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Address _____ City/State _____ Zip _____

Employer/Occupation _____

PARENT INFORMATION

(complete if patient is a minor or dependent student)

Father's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City/State _____ Zip _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer's Name _____

Mother's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City/State _____ Zip _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer's Name _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE _____ Group # _____

Subscriber Name _____ Subscriber ID# _____ Subscriber DOB _____

Phone: ( ) _____

SECONDARY DENTAL INSURANCE _____ Group # _____

Subscriber Name _____ Subscriber ID# _____ Subscriber DOB _____

Phone: ( ) _____

PATIENT HIPAA INSTRUCTIONS - (PLEASE COMPLETE AND SIGN)

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone** _____ ☐ **Work Telephone** _____

☐ **O.K. to leave message with detailed information** ☐ **O.K. to leave message with detailed information**

☐ **Cell Phone** _____ ☐ **O.K. to leave message with detailed information**

I allow you to give my clinical information to or answer questions from (check all that apply):

☐ Spouse ☐ Parent ☐ Child ☐ Other (specify): _____ ☐ None

Emergency Contact _____ Phone _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.
I authorize my dentist and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I hereby authorize my insurance company to pay directly to Joseph Ferguson, DDS any benefits for dental care rendered.

FEES & PAYMENTS

An estimate of the charge for any procedure you may require will be given to you. If you have any dental insurance we will be glad to submit your claim. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. All procedures may not be a covered benefit. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs.

X _____ **X** _____

Signature of patient (Parent or Guardian if Minor) **Date**