Welcome

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible care
To help us meet your dental needs, please complete this form.
If you have any questions, please ask- We are happy to help.

Patient Information:

Name ____ Preferred Name __________________________
Birth Date ______________ Soc.Sec.# ____________________ Driver's Lic.# ___________________
Address____ City/St/Zip ______________________________
Home Phone _______________ Work Phone ______________ Ext _____ Cell Phone _____________
Email address ______________________________________
Preferred method of communication: Please circle- Phone call Text Email
If Minor (under18) Name of Parent or Legal Guardian _____________________________________
Patient's or Parent's Employer____
Business Address _____________________________ City/St/Zip ______________________________
If Student, Name of School/College ________________ City/St _____________Full or Part time
Spouse's Name _______________________ Cell Phone ___________Work Phone_________________
Employer ____________________________
Persons to contact in Case of Emergency:
Name __________________ Relationship __________ Phone __________ (W) Phone _____________
Name __________________ Relationship __________ Phone __________ (W) Phone _____________

Responsible Party:

(If someone other than yourself is responsible for This account, please complete the following)
Name of Person Responsible for this Account _____________________ Relationship to Pt. ___________
Address ___________________________________ Home Phone _____________ Work Phone ____________
Soc. Sec. # _________________ Employer ____

Insurance Information:

Insured _____________________________________ Relationship to Patient ____________________
Birth Date _________________ Soc.Sec.# ________________ Date Employed _________________
Name & Address of Employer ___________________________________ Phone _________________
Insurance Co. _____________________ Group# _______________ Policy/ID# ___________________
Ins. Co. Address ___________________________________ City/St/Zip _________________________
Secondary Ins. _____________________ Group # _______________ Policy/ID# _________________
Insured ____________________________________ Relationship to Patient ____________________
Ins. Co. Address ___________________________________ City/St/Zip _________________________

Who may we Thank for referring you to our practice? _____________________________________

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Signature Date

As a courtesy, our office will give a 24 hour courtesy call to you to remind you of your appointment. Please be sure to keep us in mind when you change your home phone, work or cell phone numbers. We reserve our time, facilities and equipment especially for you so that you may receive quality dental care. We politely request at least a 48 hour notice if you are unable to keep your reserved appointment.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made in advance. If the account is not paid in within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I understand that my insurance is an agreement between me and my insurance company.
I also understand that I am responsible for my balance regardless of my insurance.

Authorization:

I authorize the dentist and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the use of this signature on all insurance claims and the provider to release any information required to process said claims.
I assign dental benefits paid directly to Dr. J. Beaux McCormick from my insurance company.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

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Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of treatment, various activities associated with payment and health care operations. If there is not a copy of the Notice accompanying this consent, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.
You are entitled to a copy of this Consent form after you have signed it.

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Signature Date

McCormick Family Dentistry
J. Beaux McCormick, D.M.D
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Gulfport, MS 39507
228-868-1942