Welcome to Ponchatoula Family Dentistry

Patient Information

Date________________ Soc. Sec#____________________ Birthdate________________
Name____ Home Phone_________________
Last Name First Name MI
Address____ Cell Phone________________
City_____________ State___ Zip__________ Email_____________________
Sex: [] Male [] Female [] Married []Single [] Divorced [] Separated
Primary Language Spoken____________________________
Employer____________________________ Business Phone________________________
Occupation____
Who should we thank for referring you?____
In case of an emergency, who should we contact?______________ Phone____________

Failed Appointment Contract

For the following patient: _______________________________________

If the aforementioned patient fails to appear or cancels **THREE scheduled appointments** with **less than 24-hour notice** within a **LIFETIME**, this office reserves the right to **terminate** care to that patient.
In order to avoid penalty, please make every effort to keep your scheduled appointment; if you must cancel please give us as much notice as possible. **There will be a 25.00 charge for all missed/cancelled appointments without a 24 hr notice.**

Worthless Check Contract

NSF CHECK POLICY

Payments made by check that are not honored by the bank will incur a returned check fee of $25.00. The payment will be reversed from the account which the check was written to. A collection letter is sent to the account holder notifying them of the returned. Account holder will have 10 business days to honor check for correct amount. Returned check reimbursement payments must be in the form of cash, cashier's check, certified funds or money order. If no action is taken within 10 days, account will be turned over to DA's office.

Assignment and Release

I hereby authorize payment directly to Douglas George, DDS/Ponchatoula Family Dentistry of all insurance benefits otherwise payable to me for all services rendered. I understand that I am financially responsible for charges that are not paid by my insurance. I authorize the above facility/doctor to release the information required to secure the payment of benefits.

Name____ Date______________________________