BONITA BEACH DENTAL
Dr. Grady Scott D.M.D.

New Patient Form and Disclosure Waiver

Patient's Full Name:_____ Date of Birth:_____

Wish to be called:_____ | ___Single ___Married ___Divorced ___Widowed

How did you hear about us? ___Google ___Facebook ___Newspaper ___Yellow Pages ___Other ___Reference

If other or reference, please explain how or who _____

Authorization and Release:

I authorize the treating dentist to release any information including the diagnosis, records, and photographs of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practioners.

I understand that any dental insurance contract is between my insurance company and myself, and that any charges that are incurred for services by Dr. Grady P. Scott DMD PLLC are due and payable by me at the time of service.

Financial Arrangements:

For your convenience, we offer the following methods of payments. Please check the option which you prefer. Payment is due in full at each appointment:
Cash ___ Personal Check _____ Visa ____ Mastercard____ CareCredit (3rd party payment plan) ____

I understand that failure to pay my account or to make suitable financial arrangements to pay my account will result in my account being turned over for collections. Should it become necessary to take my debt to collection, I agree to pay all collection costs which includes but not limited to collection agency fees, court cost, attorney fees and any other fees or cost for the collection of my account balance.

Thank you for completing this form – the information you have provided will help us better serve you. If you have any questions please let us know!

Acknowledgement of Privacy Practices:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission. Copy of Privacy Practice available upon request.

The information on this questionnaire is accurate to the best of my knowledge.

Patient:_____ **Patient/Legal Guardian Signature:**_____

Date:_____