RIDE THE CAVITY FREE EXPRESS TO

BRIAN BRUMBAUGH, D.D.S. & MARK SHAW, D.M.D.

Patient Name: _____ Preferred Name: _____ Date:_____

Birth Date: _____ Age: _____ Sex: **M** **F** E-mail Address: _____

Mailing Address: _____
(Street) (City) (State) (Zip)

Mother: _____ Home: _____ Cell: _____

Mother's Employer: _____ Work: _____ Ok to call at work? Y N

Father: _____ Home: _____ Cell: _____

Father's Employer: _____ Work: _____ Ok to call at work? Y N

Marital status of Parent(s): □ Married □ Single □ Separated □ Divorced
Custody Situation: Sole Custody Joint Custody **If someone does not have legal rights to patient named above, a copy of the custody order must be obtained for verification. Otherwise, single or divorced parents are assumed to have joint custody.

Name of Responsible Party: _____ Relationship to Patient: _____

SSN: _____ Birth Date: _____ Phone Number: _____

Primary Dental Insurance:

Policy Holder (Name): _____ Relationship to Patient: □ Father □ Mother □ Other

Policy Holder SSN: _____ Policy Holder Date of Birth: _____

Employer: _____ Insurance Company: _____

Phone Number: _____ Mailing address: _____

Secondary Dental Insurance:

Policy Holder (Name): _____ Relationship to Patient: □ Father □ Mother □ Other

Policy Holder SSN: _____ Policy Holder Date of Birth: _____

Employer: _____ Insurance Company: _____

Phone Number: _____ Mailing Address: _____

Consent for Services and Guarantor Agreement

By signing this form, I consent to the use and disclosure of my child's protected health information to carry out treatment, payment activities, and healthcare operations. I here-by authorize Dr. Brumbaugh, Dr. Shaw and their staff to perform any and all routine dental procedures for diagnostic/preventative purposes. If additional treatment is needed, an estimate will be presented in the form of a proposed treatment plan.

APPOINTMENT POLICY: All patients are seen on a reserved appointment basis. The procedure you are scheduling requires a definite amount of time be set aside with the dentist. This assures the best possible care for your child. As a courtesy our office provides reminders for upcoming appointments. This is done by email, text message, or telephone call. If your contact numbers change, it is your responsibility to provide updated information for your child's account. All appointments must be confirmed by text , email, or verbally with the office, Giving us this courtesy allows us to schedule another patient that needs to be seen, in the event of your cancellation. **ANY APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE WILL BE CONSIDERED A BROKEN APPOINTMENT AND WILL BE CHARGED A $35.00 FEE.** In addition, due to the stringent schedules created for Dr. Brumbaugh and Dr. Shaw, late arrivals may result in the need to reschedule your child's appointment.

I, the undersigned; have read and understand the terms of the above policies.

Signed: _____ Date: _____ Relationship to Patient: _____