



**Primary Dental Co.:** \_\_\_\_\_ I.D.# \_\_\_\_\_

Subscriber: \_\_\_\_\_  
Last First Middle

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Dental Co.:** \_\_\_\_\_ I.D.# \_\_\_\_\_

Subscriber: \_\_\_\_\_  
Last First Middle

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you a full-time student? Yes \_\_\_\_\_ No \_\_\_\_\_

**EMERGENCY CONTACT Person**

Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Last First Middle

Home Address:

\_\_\_\_\_  
Street City State Zip

Employer: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell.: \_\_\_\_\_

**Who can we thank for referring you to our office?** \_\_\_\_\_

**CONTRACT TO PAY FOR MEDICAL SERVICES:** In consideration of professional services provided to the above patient, I/we agree to pay your customary charge for these services in full, at the time of service, unless other arrangements are made with Larry L. Baker, M.D., D.D.S., P.C. I/we allow Larry L. Baker, M.D., D.D.S., P.C. to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference. I understand that a finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 90 days.

Your appointment is especially reserved for you. If you cannot keep your appointment, please inform the office 48 hours in advance so the time may be given to another patient. Added staffing is required for surgeries performed under general anesthesia. Therefore, all surgical appointments to be performed under general anesthesia require 48 hours notice prior to cancellation. A \$350.00 fee will be assessed for those surgical appointments cancelled within 48 hours and payment will be required prior to scheduling a future appointment.

**PRIVACY OF INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION:** It is the policy of Larry L. Baker, M.D., D.D.S., P.C. to maintain the privacy of all patient transactions. Larry L. Baker, M.D., D.D.S., P.C. is hereby authorized to release any medical or incidental information that may be necessary for either medical care or in processing requests for financial benefit. A copy of our Privacy Policy is available for your review.

**LEGAL RESPONSIBLE PARTY:** If the patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

**CONSENT FOR LABORATORY TESTING.** In the event that any of the office staff of Larry L. Baker, M.D., D.D.S., P.C. is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), Larry L. Baker, M.D., D.D.S., P.C. has my full consent to draw blood for the purpose of laboratory testing. This will ensure the safety of all parties who are concerned and involved.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

