GREGORY M. SWEENEY JR.
D.M.D., P.C.
COMPREHENSIVE & RESTORATIVE DENTISTRY

RECEIVE APPOINTMENT REMINDERS VIA EMAIL, TEXT OR CELLPHONE

PLEASE SELECT THE MANNER IN WHICH YOU WOULD LIKE TO RECEIVE REMINDERS

_____ Email

_____ Text Message

_____ Email and Text Message

Email Address: _____

Cell Phone: _____

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Dr. Gregory M. Sweeny, Jr. in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. These parties may use your email or any numbers associated with your account, to better provide adequate service with your account or to collect monies you may owe.. Your PHI may be disclosed to an affiliate that performs services for Dr. Gregory M. Sweeney, Jr. in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send and email or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

Print Name_____

Signature_____ Date_____

9815 Millwood Circle Daphne, AL 36526 • Phone: 251.626.7226 Fax: 251.626.7221

sweeneydmd@gmail.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

** You May Refuse to Sign This Acknowledgement**

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

(__) Individual refused to sign

(__) Communications barriers prohibited obtaining the acknowledgement

(__) An emergency situation prevented us from obtaining acknowledgement

(__) Other (Please Specify)

MISSED APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS PRIOR TO THE APPOINTMENT WILL HAVE A $25.00 CHARGE ADDED TO THEIR ACCOUNT

AUTHORIZATION AND FINANCIAL RESPONSIBILTY

I hereby authorize payments to Dr. Gregory M. Sweeney, Jr. of any insurance benefits available for payment on this account. I understand that Dr. Sweeney's office will attempt to file on any available insurance but this office is not responsible for the processing and handling of any insurance claim nor is acting as your agent for processing and handling of any insurance claim on your behalf. I am responsible for the entire account balance in the event that there is no insurance payment. Accounts that have not been paid in full within 30 days, unless other arrangements have been made, will be submitted to a collection agency. Failure to make payments as agreed upon is basis for legal action and the undersigned agrees to pay all cost of collection including reasonable attorney fees and does hereby waive their rights of exemption under the laws of the U.S. Constitution of the Sate of Alabama and any state.

SIGNATURE_____ DATE_____

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PATIENT REGISTRATION

Date:_____

Patient's First Name_____ Middle Initial_____ Last Name_____ Nickname_____

Address _____ City_____ State ____ Zipcode_____

Patient's Home #_____ Work #_____ Cell #_____

Date of Birth_____/_____/_____ Social Security Number:_____-_____-_____

Sex: M(__) F(__) Martial Status: (__) Married (__) Single (__) Widowed (__) Divorced

Occupation_____ Employer_____

In case of an emergency, whom should be notified?_____

Name of Spouse (if applicable)_____ Spouse Contact Number:_____

Occupation of Spouse_____ Employer_____

Spouse Date of Birth ____/_____/_____ Spouse's Social Security Number_____-_____-_____

Person Responsible for account (if not yourself)_____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Primary Insured Party's Name_____ Social Security Number_____

Relationship to Patient: Self (_) Spouse (_) Parent/Step Parent (_) Other (specify):_____

Insurance Company Name_____

Ins. Address_____ Ins. Phone #_____

Group Number _____ Subscriber ID_____

Secondary Insured Party's Name_____ Social Security Number_____

Relationship to Patient: Self (_) Spouse (_) Parent/Step Parent (_) Other (specify):_____

Insurance Company Name_____

Ins. Address_____ Ins. Phone #_____

Group Number _____ Subscriber ID_____

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