John S. McInturff, DDS - 1205 SE Professional Mall Blvd., Suite 202 - Pullman, WA 99163
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New Patient Registration/Information/HIPAA Release

By signing this form you acknowledge receipt of our HIPAA Privacy Policy and allow Dr. McInturff's office to use and disclose your protected health information to carry out treatment, billing activities, payment activities, and health care operations. Unless revoked in writing, this consent is valid for the duration of your care from Dr. McInturff.

Patient Name: _____

Address:_____**City:**_____**State:**_____**Zip**_____

Phone (_____)_____ **Cell Phone (_____)**_____ **Email:** _____

Date of Birth: _____ **Social Security Number:** _____

Primary Care Provider:_____ **Preferred Pharmacy** _____

Please contact me: (check all that apply) ☐ **A.M.** ☐ **P.M. On my:** ☐ **Home phone** ☐ **Work phone** ☐ **Cell phone** ☐ **E-MAIL**

Person to contact in case of emergency_____ **Phone**_____

In order to submit a dental claim for your care we need ALL of the following insurance information!

DO YOU HAVE DENTAL INSURANCE? ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING:**

Name of Subscriber: _____ **DOB**_____ **SSN#:** _____

Phone: (_____)_____ **Subscriber's Address** _____

Subscriber's Employer: _____ **City**_____**State:**_____**Zip** _____

Insurance Company_____ **Grp #**_____ **ID#**_____

DO YOU HAVE 2nd DENTAL INSURANCE? ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING:**

Subscriber's Name _____**DOB**_____ **Phone (_____)**_____

Employer _____ **Phone (_____)**_____

Insurance Company_____ **Grp #**_____ **ID#**_____

I understand that I am responsible for payment in full, regardless of the amount or level of my dental insurance benefits. I agree to pay promptly any amount not covered by my insurance. On charges outstanding more than 90 days following payment of dental insurance, I agree to pay interest charges of 1.0% per month, compounded monthly, and all costs incurred to collect any outstanding balances allowed by law. I will pay a $25 fee for appointments missed without 24-hours notice.

I have read/understand the Notice of Privacy Practices available on my request from Dr. McInturff. I authorize my previous dentist to release any X-rays, images, or clinical information to Dr. McInturff to assist in my continuing care:

Previous dentist: _____ **Phone number:** _____

DATE OF MOST RECENT X-RAYS or DENTAL VISIT: _____

DATE:_____ ***Signature:***_____