MONOCACY VALLEY DENTAL
BRIAN MOTZ, DDS

We would like to get to know you better!

65 Thomas Johnson Dr., Suite B
Frederick, MD 21702
Office (301) 698-0044

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www.monocacyvalleydental.com

Date:_____

Name:_____ Prefer to be called:_____ □ Male □ Female

DOB:_____ SS#:_____ Marital Status: □ Married □ Single □ Divorced □ Other □ Minor

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

Primary Phone:_____ Secondary Phone:_____ Email:_____

Whom may we thank for referring you to our office? _____ Contact preference: □ Call □ Text □ E-mail

Primary Care Physician: _____ Phone: _____

Emergency Contact:_____ Phone:_____ Relationship to patient:_____

Person financially responsible for this account? _____ Relationship:_____

For Insurance Purposes:

Name of Insured:_____ DOB:_____ Relationship to Patient:_____

Primary Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Employer:_____ Occupation:_____ Secondary Coverage? □ Yes □ No
If yes, please complete Secondary Insurance info.

Secondary Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Employer:_____ Occupation:_____

Assignment and Release:

I certify that I (or my dependent) have insurance coverage and assign directly to Brian K. Motz D.D.S. (dba *Monocacy Valley Dental*) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges irregardless of insurance reminsbursement. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Motz to perform any necessary examination and radiographs needed for proper diagnosis.

I hereby authorize the doctor to release my protected health information to carry out payment activities in addition to treatment and health care operations. *(You have the right to read our Privacy Practices. This notice provides a description of our treatment, payment activities, and healthcare operations, as well as the uses and disclosures we make of your protected health information. A copy of our Notice of Privacy Practices is available upon request).*

Responsible Party's Signature:_____ Date:_____ Relationship: _____

Cancellation and Missed Appointments:

Our practice is dedicated to quality care and exceptional service. Dr. Motz and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a 24 hour notice so that we may make every effort to accommodate other clients.

I understand that if proper notice is not received, a fee of $50.00 will be charged to my account. I understand this fee is not covered by insurance.
**Appointments reserving more than 1.5 hours will be charged a fee of $100.00.*

Responsible Party's Signature:_____ Date:_____ Relationship: _____