PATIENT INFORMATION

Patient Name:_____
(Last) (First) (Middle Initial)

Preferred Name:_____ DOB:_____ Age:_____ Gender: ___M ___F

Family Status: ___Married ___Single ___Child ___Other SSN:_____

Email Address:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Address:_____

_____

Employer Name:_____Phone:_____

Employer Address:_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name:_____

Phone:_____Relationship:_____

Address:_____

As a courtesy, patients are asked to confirm their appointments at least 48 hours in advance by responding to our confirmation contact (phone call or text) or by directly contacting our office.

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder:_____
(Last) (First) (Middle Initial)

Relationship to patient: (spouse, parent, etc)_____

DOB:_____ Gender: ___M ___F Family Status: ___Married ___Single ___Child ___Other

Insurance Plan Name: _____ Insurance Phone#: _____

ID #: _____ Group:#: _____

Claims Address:_____

Employer Name:_____Phone:_____

Employer Address:_____

Whom may we thank for your referral / How did you hear about our office?:_____

_____

PRIMARY MEDICAL INSURANCE

Name of Policy Holder:_____

Relationship to patient (spouse, parent, etc.)_____

Insurance Plan Name:_____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing. Please let us know if you would like more information about financing options.

Please note: Returned checks will be subject to additional fees. In case it becomes necessary for our office to enlist a collection service and/or legal debt collection assistance, you will be responsible for, and agree to pay office, all collection and/or legal fees, costs and expenses up to 35% of debt.

Do you have insurance?

*We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

*As a courtesy to you, we will help you process all your insurance claims. Please understand that we provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

*We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

*We ask that you pay the deductible and co-payment, which is the ESTIMATED amount, NOT covered by your insurance company at the time we provide the service to you.

*We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental healthcare needs and welcome any questions you may have concerning your care or our financial policy.

- ☐ I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Signature of patient, parent or guardian (responsible party):_____

Relationship to Patient:_____ Date _____