WELCOME

Patient Information

Today's Date: ____/____/____

Patient Name: _____ Preferred Name: _____
First MI Last

Mailing Address:_____
City State Zip

Home Phone #: ( ) _____Work Phone #: ( ) _____ Cell Phone # : ( ) _____

Which number would you prefer to be confirmed at: Home ____ Work ____ Cell ____

Birthdate: _____/_____/_____ Male ___ Female ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

SS#: _____ Drivers License #: _____

(If Married) Spouse Name: _____

Are you a Full Time Student? No ___ Yes ____ (If Yes) Where: _____

Place of Employment: _____ Address: _____ Occupation: _____

Emergency Contact Name: _____ Phone# ( ) _____ Relationship: _____

E-mail Address: _____ **REFERRED BY**: _____

Account Information

Person responsible for account (Fill out **ONLY** if patient is under 18 years of age)

Name: _____ Relationship to Patient: _____

Mailing Address: _____
City State Zip

Home Phone #: ( ) _____Work Phone #: ( ) _____ Cell Phone # : ( ) _____

Birthdate: _____/_____/_____ Male ___ Female ___

SS#: _____ Drivers License #: _____

Place of Employment: _____ Employment Address:_____

Insurance information

Primary Dental Insurance

Subscriber/Policy Holder Name: _____ Birthdate: ___/___/___

Relationship to Patient: _____

Place of Employment: _____ Employment Address: _____

Name of Insurance: _____ SS# _____ or ID# _____ Group # _____

Insurance Mailing Address: _____ Telephone #: ( )_____

As a courtesy we will file any secondary insurance as applicable, however you are financially responsible for any estimated co-pays based on your primary insurance. You will be notified of any additional payments from your secondary insurance at which time you can request a refund or have the credit applied to your account for future treatment.

Secondary Dental Insurance

Subscriber/Policy Holder Name: _____ Birthdate: _____/_____/_____

Relationship to Patient: _____

Place of Employment: _____ Employment Address: _____

Name of Insurance: _____ SS# _____ or ID# _____ Group # _____

Insurance Mailing Address: _____Telephone #: ( ) _____

FINANCIAL POLICY

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top quality care as cost effective as possible. To promote a long term mutually satisfying relationship, we would like to explain our office policy regarding payment options, insurances, appointments and fees.

PAYMENT OPTIONS: Payment for service is due at the time that services are rendered. When insurance applies we will collect any deductible and/or estimated co-payment at the time of service. We accept cash, check, Visa, MasterCard and Discover. In addition, we offer financing through Care Credit and Lending Club for those requiring payment plans.

INSURANCE: We will gladly discuss your proposed treatment, answer any questions relating to your insurance and provide you with an ESTIMATE of what your insurance company will pay towards your treatment. Our office can make no guarantee of the actual payment by your insurance company. Filing of insurance claims is a courtesy we extend to our patients. You must realize; however, that your insurance is a contract between you, your employer and your insurance company. You are FULLY RESPONSIBLE for the charges for the treatment rendered.

Primary Insurance Information:

Primary Insurance Company: _____Subscriber: _____

Subscriber's DOB: _____Relationship: _____ID #: _____Group #: _____

Secondary Insurance Information:

Primary Insurance Company: _____Subscriber: _____

Subscriber's DOB: _____Relationship: _____ID #: _____Group #: _____

MISSED APPOINTMENTS: Appointments are made on a per appointment basis and this time is reserved exclusively for you. As a courtesy, we attempt to remind you of your appointment by calling you, sending emails and/or texts to those patients who have signed up for these options; however, it is ultimately the patient's responsibility to keep their scheduled appointments.

When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is unable to receive treatment. We require that you give us at least 24 hours' notice when you realize that you cannot keep your scheduled appointment. A fee of $50 will be charged for all missed and short notice (less than 24-hour notice) cancelled appointments. After hours, our office has a 24-hour answering service that allows you to speak directly to someone.

Your signature below acknowledges that you received this form and you fully understand all of our policies.

_____ _____

Patient/Guardian Signature Date