Welcome

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you.

PATIENT INFORMATION (CONFIDENTIAL) Name you would like to be called:_____

Name_____ D.O.B._____ SS: _____

Email: _____Home PH: _____Work No. _____ x _____

Address _____City/State/Zip _____Cell _____

Check Appropriate ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Age: _____ Circle: MALE FEMALE

Employer: _____ Occupation: _____

Person to Contact in Case of Emergency _____ Phone _____ Cell _____

Whom may we thank for referring you? _____ Office Last x-rays taken _____When _____

Responsible Party (if different from patient)

Name_____ D.O.B._____ SS No_____

Home PH: _____ Cell PH_____ Work PH. _____ x _____Drivers License_____

Address _____City/State/Zip _____ _____

Email _____ Are any other family members currently a patient in our office? _____

Methods of Payment offered: ***Cash or Personal Check, Credit Cards: Visa, MasterCard, Discover Card and American Express***

Insurance Information (Person who is the Subscriber (employee) on the insurance)

Insured Name_____ SS No. _____ D.O.B. _____

Employer _____Contract/ID (from card) _____ Ins. Co. Phone _____

Insurance Company _____ Patient relationship to employee? Spouse Child Other

THIS OFFICE SUBMITS INSURANCE AS A COURTESY TO OUR PATIENTS. THIS PRACTICE DOES NOT ACCEPT RESPONSIBILITY FOR BENEFITS PAID OR NOT PAID BY YOUR INSURANCE COMPANY. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES.

OUR STAFF ESTIMATES YOUR PORTION DUE AT THE TIME OF SERVICE. IF YOU WISH TO KNOW YOUR EXACT COST EACH VISIT, YOU MAY PAY IN FULL AT THE TIME OF SERVICE AND WAIT FOR YOUR INSURANCE COMPANY TO REIMBURSE YOU DIRECTLY. THIS IS THE ONLY FOOL-PROOF WAY TO ENSURE THAT YOUR ACCOUNT BALANCE REMAINS CURRENT AND ACCURATE WITH THIS OFFICE. IF INSURANCE PAYS MORE THAN EXPECTED, YOU WILL RECEIVE A REFUNDUPON REQUEST OR YOU CAN CHOOSE TO APPLY THE CREDIT TO NEXT SERVICE. IF INSURANCE PAYS LESS THAN EXPECTED, YOU WILL BE BILLED FOR THE DIFFERENCE.

SOME SERVICES MAY BE DOWNGRADED TO A LOWER RATED SERVICE THAN THE SERVICE WE PROVIDE FOR INSURANCE COVERAGE PURPOSES AND YOUR PLAN MAY REQUIRE YOU TO PAY THE DIFFERENCE. SOME EXAMPLES ARE POSTERIOR COMPOSITE RESTORATIONS AND CROWNS.

Consent: 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. The undersigned hereby authorizes the Doctor/Staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk of numbness however rarely permanent. 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 prior financial arrangements have been made. I understand that a finance, rebilling, collection charge or attorney fees may be added to any overdue balance of more than 60 days.

Patient Signature (Parent of Child): _____ _____

Name Date