PATIENT INFORMATION

Patient Name ______________________________ Date of Birth __________

Social Security Number ____________________ E-mail Address ____________________

Home Phone ____________________ Cell Phone ____________________

Address ____________________ City __________ State ______ Zip ______

Employer ____________________ Work Phone ____________________

RESPONSIBLE PARTY

Name ______________________________ Date of Birth __________

Social Security Number ____________________ E-mail Address ____________________

Home Phone ____________________ Cell Phone ____________________

Address ____________________ City __________ State ______ Zip ______

Employer ____________________ Work Phone ____________________

SPOUSE OF RESPONSIBLE PARTY

Name ______________________________ Date of Birth __________

Social Security Number ____________________ E-mail Address ____________________

Home Phone ____________________ Cell Phone ____________________

PRIMARY INSURANCE

Insured's Name ______________________________Date of Birth __________

Social Security Number ____________________ Employer ____________________

Insurance Company Name ____________________Dental Group #__________

Dental ID Number ______________________________

SECONDARY INSURANCE

Insured's Name ______________________________Date of Birth __________

Social Security Number ____________________ Employer ____________________

Insurance Company Name ____________________Dental Group #__________

Dental ID Number ______________________________

GENRAL INFORMATION

Nearest Relative Not Living With You ____________________ Phone Number __________

Nearest Friend Not Living With You ____________________ Phone Number __________

The Dental Practice Financial & Appointment Policy

Accepted Payment Types

We accept cash, check, most major credit cards and Care Credit.

We ask for cooperation from all our patients to pay for services the day of treatment, including those with dental insurance. By paying for treatment on the day of service, or the estimated patient portion, it helps us to reduce bookkeeping and billing expenses that increase the cost of your care.

There is a process fee for all return check or invalid credit card payments.

Cash, Check, or Credit Card Patients

We ask that all single day services be paid on the day of service. This includes the patient poriton for those with dental insurace.

Fees greater than $400 paid in full before treatment =5% discount
Fees greater than $2000 paid in full before treatment = 7% discount

*In these cases, if there are insurance benefits, the insurance portion is not eligible for the discount.

All previous balances must be paid before any bookeeping allowance will apply.

*Accounts are aged from day of service. There may be a $5.00 re-billing fee added to all unpaid charges after 90 days. This includes unresolved insurance claims.

Senior Courtesy

Patients over 65 will receive a 5% bookkeeping allowance on all fees over $100 that are paid in full on the day of treatment or at the beginning of a treatment series.

Insurance Patients

The patient or guarantor is ultimatley responsible for all account balances regardless of insurance coverage.

Not all services are covered benefits in all contracts. Your employer has selected the level of coverage based on the premuim paid.

We submit insurance claims as a patient courtesy, however that contract exists between the patient/insured and the insurance compnay. We try to help all patients receive the maximum beneifits their plans will allow for the treatment they need. Our business is providing excellent dental care. The insurance industry has made it nearly impossible for patients to file their own claims. When or if there are insurance difficulites, please know that we are working on your behalf and we pledge to do our best.

In most cases you have authorized insurance payments to come directly to us. We will estimate your portion based on historical information from your insurance company. Your portion is due the day of service. Please be prepared to pay your estimated patient portion.

A few companies send the insurance payment to the patient. We will still file the claims on your behalf as a courtesy. The Payment is your responsibility at the time of service.

To speed up insurance processing, it is important that you are familiar with your insurance coverage and provide us with accurate information. Plase bring current dental insurance information with you. This is your responsibiltiy.

Broken Appointments

In the event of repeated broken appointments or short notice cancellations (less the 48 hours). we may require a $50 deposit to reschedule.

I understand and agree that (regardless of my insurance status), I am ultimatley responsible for the balance on my account for any professional services rendered, as well as any finance charges, collection costs, or multiple rebilling charges. I have read the financial policy for this office, and understand my obligations.

I authorize release of any information relating to any claim. I authorize payment directly to The Dental Practice for benefits otherwise payable to me. I leave my signature on file for future claims that relate to me.

Patient Signature ______________________________ Date ________________

(if under 18, signature of parent or guardian)