

Patient Information

Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:
 City State Zip Code

SS# (for verification of insurance) Drivers Licence Number/State

Full-time students, please list the school name:

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:
 City State Zip Code

Emergency Contact information:

Last Name	First	Relationship to patient
<input type="text"/>		

Address	City	State	Zip
<input type="text"/>			

Home#	Work#	Cell#
<input type="text"/>		

Whom may we thank for referring you to our practice?

- Dental Office
- Internet
- Yellow Pages
- Sign/location
- Friend, family, co-worker, other _____

Preferred appointment times:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Morning
- Afternoon
- Anytime

Nancy M. Stewart, DDS, PC
Cosmetic & General Dentistry
2754 N Decatur Rd, Ste 111
Decatur GA 30033-5917

(404)299-0123
SMILE@drnancystewart.com
www.drnancystewart.com

Primary Dental Insurance Information

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dental practice of Nancy M Stewart DDS PC to be applied directly to any outstanding balance on my account.

I understand that the dental practice of Nancy M Stewart DDS PC is not a participating provider of any insurance network plans and is considered an out-of network provider.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: _____

Date:

Secondary Dental Insurance Information

We do not accept secondary insurance assignment without prior approval but, as a courtesy to you, we will be happy to provide you with the necessary information and help you file your claim.

Secondary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All EMERGENCY DENTAL SERVICES, or any dental services performed without previous financial arrangements, must be PAID FOR IN FULL at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

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

Signature: _____

Date:

Relationship to Patient:

Response Date: