WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of 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.**

Today's Date: _____________

PATIENT INFORMATION:

Name: ____
Wishes to be called: __________________________ SS# _________________
Male ( ) Female ( ) Birth date: _____________________
Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Minor ( )
Address: ____
City/ State/ Zip Code: ____
Employer: _______________________ Occupation: __________________
Referred by: ____

TELEPHONE INFORMATION:

Work Phone: ______________ ext#: _____ Home Phone: ____________
Cell Phone: _______________ E-mail Address: _____________________
Where do you prefer to receive calls? Work ( ) Home ( ) Cell ( )
When is the best time to reach you? _________________________________
In the event of an emergency, whom should we contact?
Name: ______________________ Relationship: ___________________
Work Phone: _______________ Home Phone: ___________________

PRIMARY DENTAL INSURANCE INFORMATION:

Policy Holder: _______________________ Relation to Patient: __________
Birth date of policy holder: ____________ Social Security #: ____________
Driver license # ________________
Address (if different than patient) ____
City/State/ Zip Code: ____
Employer: ______________________ Occupation: _____________________
Insurance Company: ________________ Group Number: _______________
Insurance Company Address: _______________________________________
City/ State/ Zip Code: ____
Insurance Phone: ______________ Subscriber ID Number: ____________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: (FILL OUT THIS AREA IF THE PATIENT IS A MINOR)

Name: ________________________ Birth Date: ______________________
Relationship to patient: ______________ Social Security #: ____________
Address: ____
City/State/Zip Code: _______________ Home Phone: __________________

PLEASE SEE OTHER SIDE

It is the policy of this practice to request payment in full at the time services are rendered.

Methods of Payment:

We accept Visa, MasterCard, Discover, personal checks, money orders and cash.

Returned Checks:

A fee of $25 will be charged for all returned checks.

Missed Appointments:

We ask that if you cannot keep a scheduled appointment that you cancel at least 24 hours prior to that appointment. Failure to do so will result in a late cancellation or missed appointment fee of **$75**. These fees are not reimbursed by any insurance company and are the direct responsibility of the patient.

Payment of Account:

Should your account be turned over to an agency for further collection procedures, a 35% fee will be charged to your account.

Signature of Understanding:

I have read and understand the above financial policy. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.**

_______________________________ _______________________

Patient/Guardian Signature **Date**

Authorization for Insurance

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Drs Davis, Anderson and Swain.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

_______________________________ _______________________

Patient/Guardian signature **Date**