# DOCTORS CLARK & LESTER

**Family Dentistry**

**Patient Information Form**

**Today's Date:** _____

**LEGAL name:** _____ **Name you prefer:** _____ **Male___Female ___**
**Date of birth:** _____ **SS#** _____ **Married Single Widowed**
**Mailing address:** _____ **City** _____ **State** ____ **Zip Code**_____
**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____
**Name of employer/Name of college attending** _____ **Occupation** _____
**Referred by:** _____ **Do we provide dental care to any members of your family:**
**If yes, name:** _____ **Relationship to you:** _____
**Emergency contact person:** _____ **Phone #:** _____

## Insurance Information

****This information MUST be completed prior to treatment**

**Name of Employee/Subscriber:** _____
**Date of birth:** _____ **Relationship to Patient:** _____
**Name of Employer:** _____
**Address(if different from patient):** _____ **City** _____ **State** _____ **Zip Code** _____
**SS#** _____
**Name of Insurance Company:** _____ **Group #:** _____
**Insurance Company Phone #:** _____

## Accountholder Information/Responsible Party

**Person signing this form is responsible for any money due for the above patient.

**Name of accountholder If different from patient:** _____ **DOB:** _____
**Address ONLY if different from patient address:** _____

**Home phone:** _____ **Work phone:** _____ **Cell phone:**_____
**Relationship to patient:** **Self** **Spouse** **Child** **Other:** _____
**Responsible party sign here:** _____ **Date signed:** _____

**Parent or Guardian MUST sign this form PRIOR to treatment. Must be at least 18 years of age to sign.**
***NOTE–THIS FORM SIGNED IN SHELBY COUNTY AND ALL SERVICES ARE PERFORMED IN SHELBY COUNTY.**

### FINANCIAL TERMS & AGREEMENT

We realize every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

### DENTAL INSURANCE

Our office will file your claims with most dental insurance carriers to assist you in receiving your benefits. <u>However, we make no guarantee of any estimated coverage.</u> Because your insurance policy is an agreement between you and your insurance company, all patients are directly responsible for all charges. CO-PAYMENT and/or YOUR ESTIMATED PORTION OF ANY CHARGE IS DUE ON THE SAME DAY OF THE SERVICE. If for any reason your insurance has not paid your claim within 60 days from the date of service, you are responsible for full payment at the time. In this event, once full payment is received in our office, we will assist you in receiving reimbursement from your insurance company. We will file only with your primary dental insurance.

### YOUR PAYMENT OPTIONS AT THE TIME OF SERVICE

**Cash, Personal check, MasterCard, VISA, Discover & Care Credit (with approved credit)**

**IF IT BECOMES NECESSARY TO TURN THIS ACCOUNT OVER FOR COLLECTIONS, I PROMISE TO PAY ALL ATTORNEY'S FEES, COURT COST, & ALL OTHER COSTS OF COLLECTION OF MY ACCOUNT.**

The undersigned agrees to pay for all services rendered. This form was signed in Shelby County and all services are performed in Shelby County.

**WHAT TYPE PAYMENT WILL YOU BE USING IN OUR OFFICE?**

__ CASH __ CHECK __ VISA/MC __ DISCOVER __ CARE CREDIT (with approved credit)

***A $25 OFFICE FEE WILL BE CHARGED TO YOUR ACCOUNT UNLESS A 24-HOUR CANCELLATION NOTICE IS GIVEN.**

**X** _____ _____

**GUARANTOR – PATIENT OR GUARDIAN IF PATIENT IS A MINOR** **TODAY'S DATE**