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Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

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) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Whom may we thank for referring you to our practice? *

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Employment Information

Employer name and occupation: *

_____

_____

Emergency Contact/Spouse or Responsible Party Information

This information is for: *

☐ Emergency Contact ☐ Spouse ☐ Responsible Party for Payment

First and Last Name: * _____

Address: _____ * (Address 1) _____ (Address 2)

_____ * (City) _____ * (State) _____-____ * (Zip Code)

Phone: _____ * (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

I attest that the above information is correct and will be used for billing and contact purposies to coordinate my care.

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

Signature _____ **Date** _____

Do you have active dental insurance? * ◯ Yes ◯ No

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

What is the main subscriber's birthday?: _____

Insurance Plan ID#: _____

Insurance plan Group ID: _____

Insurances require a social security number to verify benefits. Please enter your social security number: _____

A Note on Dental Insurance:

Patients with dental insurance understand that their insurance plan is unique to their company or person. There are thousands of insurance plans even in the same insurance Carrier. As such, the arrangement of payment is an agreement between the patient and the insurance company.
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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 completely by an insurance company.
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Patients understand that the insurance company will be charged first after treatment and any unpaid balance is the full responsibility of the patient unless financial arrangements are made with the office in advance.
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I understand that any fee estimate for this dental care is only an estimate given our history with past experience with the insurance companies. A patient is ultimately responsible to understand the insurance fees they may receive. Should a more exact estimation be necessary, a pre-determination may be made in advance of treatment. Unfortunately pre-determinations may take weeks or months to be returned by the insurance company. This is why many patients use our estimates and proceed with necessary treatment as soon as possible.
-
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services within fifteen (15) days of billing after insurance payment is disbursed.
-
I grant my permission to you or your assignee, to telephone, email, or text me to discuss this statement or my treatment.

I understand the role of dental insurance may have in the care I recieve.

Signature _____ **Date** _____

Please bring your insurance card to the front desk so we may attain a copy.

Financial Agreement

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients and dental insurance companies, should they have them, for the costs incurred in their care.

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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 fifteen (15) days of billing if credit is extended. I understand that payment plans are available and need to be set up prior to services rendered. Should I miss a payment I agree to be contacted by the office to remedy the situation and I will be prompt in returning the call. I understand that payments not remedied will be sent to collections.

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

I understand my responsibility of payment:

Signature _____ **Date** _____

Response Date: _____