Patient Information Form **Today's Date _____**

Patient Name:

First_____Last_____

Nickname _____

Address: Street_____City_____

State _____Zip _____

Phone: Home _____

Mobile _____email _____

Social Security Number _____Date of Birth _____

Patient Employed By _____Occupation
_____Phone _____

Address: Street _____City
_____State _____Zip _____

Sex Male ___ Female_____ **Marital Status**_____ Married_____ Single_____
Divorced_____Separated___ Widowed_____

In case of emergency, who should be notified?

_____

Relationship to Patient _____

Home Phone _____Mobile Phone _____

Is the patient a Minor? ____Yes_____No Full-time Student _____Yes_____No

Name of Responsible Party:

Name_____

Date of Birth _____Relationship to Patient Spouse_____Parent _____

Other _____

Dental Benefit Plan Information

Primary Dental Plan Name

_____

Phone _____

Address:

Street_____City_____

State_____Zip _____

Name of Insured_____

Date of Birth _____ID Number _____

Policy Number _____

Patient Relationship to Insured _____

Whom may we thank for referring you? _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice IS / IS NOT a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services

from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly

from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan

to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and

obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require **48-hour notice to reschedule** an appointment. **With less than 48-hour notice, a fee of $40.00 or deposit to reserve the appointment time again**, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $40.00 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____(initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____(initial)

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____(initial)

Signature Print Date