

Welcome to our Practice

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: _____

SS#: - - - - -

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

Please enter Employer and Occupation

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This ONLY needs to be filled out if the patient is under 18 years.

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

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

Birth Date: _____ **SS#:** - - - - - **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

Primary Dental Insurance:

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Authorization:

- By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

FINANCIAL POLICY ACKNOWLEDGMENT

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, Visa, MasterCard, and Discover. We also have partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. Check Policy: If your check is returned for any reason, you will be charged a processing fee of \$25.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment. Should you find it necessary to reschedule an appointment, please provide us with a notice of twenty-four (24) hours.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers in the Delta Dental Premier Network and Blue Cross Blue Shield Indemnity Plan; however, we do not participate in any other PPO network plans.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

IMPORTANT FACTS ABOUT YOUR DENTAL INSURANCE
. Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
. It is your responsibility to understand the type of dental insurance you have (i.e., Traditional, PPO, DMO), and the benefits selected by you and/or your employer.
. You (not the insurance company) are responsible for the fees of services rendered.

- By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy Acknowledgment.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Response Date: ____/____/____