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 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.

Personal Information

Name: _____ Today's Date_____
Please circle one: Mr Mrs Miss Ms Dr None Preferred Salutation _____
Birthdate: ____/____/____ Social Security Number: _____-____-_____
Minor ____ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___
Address: _____
City, State, Zip: _____
Employer: _____ Occupation_____
Employer Address: _____
How did you hear of our office?_____

Responsible Party

Who will be responsible for this account?
Name_____ Relationship to Patient_____
Birthdate: ____/____/____ Social Security Number: _____-____-_____
Address: _____
City, State, Zip: _____
Employer: _____ Occupation_____
Employer Address: _____
Home Phone _____ Work Phone _____

Contact Information

Home Phone _____ Work Phone (Ext.) _____
Cell Phone _____ Fax _____
Email address: _____
How do you prefer for us to contact you? (Circle one) Home Work Cell Text Email
When is the best time for us to reach you? Time _____ Days _____
In the event of an emergency, whom should we contact?
Name _____ Phone _____ Relationship _____

Dental Insurance Information

Are you covered by a dental insurance plan? NO _____ YES _____
Insured Name _____ ID# _____ Birth Date ____
If you would like to use your dental insurance for your visits, please provide a claim form and a copy of your insurance information card. Thank you. **(Continued on back)**

Office Policy Regarding Scheduled Appointments

We will be happy to schedule your appointment at a time convenient for you within our office hours. We ask for at least 48 hours notice if you need to cancel or change the appointment. This notice time allows us to offer the appointment time to another patient who is in need of dental treatment. There will be no failed appointment charge applied to your account provided we receive 48 hours notice.

_____ Initial here after reading the above policy

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the dentist or Dental Corporation insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ Date _____

Signature of patient or parent if minor

Financial Arrangements

For your convenience, we offer the Following methods of payment. Please check the option you prefer.

Payment in full is due at each visit.

_____ Cash
_____ Personal Check
Credit Card _____ Visa
_____ Master Card
_____ Discover

Late Charges

If I do not pay the entire balance within 25 Days of the monthly billing date, a late charge of 1.8% (21.6% per year) of the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies and where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

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