



Welcome to Bellevue Family Dentistry!

Patient Information

Name (Last, First, Middle Initial) _____ Date _____
Birthdate _____ SSN _____
Home Phone (_____) _____ Cell (_____) _____
Address _____
City _____ State _____ Zip Code _____
Email _____

Check Appropriate Box: Minor Single Partnered Married Separated Divorced Widowed

Patient's Employer _____ Work Phone _____
Business Address _____ Full Time Part Time
City _____ State _____ Zip Code _____
Spouse or Parent/Guardian's Name _____
Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone (____) _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address (if different from above) _____
Phone _____ Email _____
Birthdate _____ SSN _____
Employer _____ Work Phone _____
Is this Person Currently a Patient at this Office? YES No

For your convenience, we offer the following methods of payment. Please check the option that you prefer: Cash Personal Check Visa MasterCard Discover AMEX Care Credit

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ ID # _____
Ins. Co. Address _____
City _____ State _____ Zip _____
Provider/Customer Service Phone Number _____

Do You Have Additional Ins? YES NO (if yes, please let the front desk know)

Patient Name _____ Date of Birth _____

Financial Options and Payment Agreements

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and your payment options. Please check the preferred payment plan for your family:

- PLAN A:** Payment as services are rendered will reward you a 5% discount at the time of service.
- PLAN B:** 6 month payment plan using a major credit card (MasterCard or Visa)
- PLAN C:** *Care Credit* is a 12 month, same-as-cash option, and our staff would be happy to assist you with the application process.
- PLAN D:** We will gladly bill your insurance plan, with your understanding that you will be responsible for the amount not covered.

I, _____, have chosen Plan ___ above and accept full responsibility for this account. I understand that I am responsible for understanding my insurance benefits, if applicable. I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance. I understand that any insurance estimate given is not a guarantee of actual insurance payment or coverage. I also understand that I am responsible for all charges incurred for dentistry performed upon me and my dependents. Any insurance claim not paid in full after 60 days will become my responsibility at that time. In addition, I also agree to pay for all costs of collection, including attorney fees, and court costs, should additional means of collection be required.

Authorization and Release Agreement

In regards to my medical history, I certify that I have read and understand all of the information provided to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information, or not providing information, can be dangerous to my health.

X _____ Date _____

HIPPA

Has my permission to receive my information:

Name _____ Phone _____
Name _____ Phone _____

I, (Please print name) _____, have received a copy of this office's Notice of Privacy Practices.

X _____ Date _____