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 ___________________

HIPAA

Has my permission to receive my information:

Name ____ Phone__________________

Name ____Phone__________________

I, (Please print name) _____________________________________, understand the Notice of Privacy Practices.

X____ Date ____________________