PATIENT ACCOUNT INFORMATION

Patient's Name: _____ (First) _____ (Middle Init.) _____ (Last) Birthdate: _____

Home Address: _____ Yrs. at Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext: _____

Marital Status: S M W D To whom should the statement be sent? _____

Occupation: _____ Employed by: _____

Closest Relative not living with you: _____ Phone: _____

Confirm my appointment at: ☐ Home ☐ Office Best time to call is between _____ and _____

If an opening occurs would you desire an earlier appointment? ☐ Yes ☐ No

The name of the person we thank for referring you:

☐ Relative _____ ☐ Employee of this office _____

☐ Patient of this office _____ ☐ Yellow Pages ☐ Bell of PA ☐ Donnelly

☐ Doctor _____ ☐ Newspaper _____

☐ Business Associate _____ ☐ Other _____

Years since last comprehensive dental examination? _____

Were periodontal (gums) pocket readings charted? ☐ Yes ☐ No

Was all prescribed treatment completed? ☐ Yes ☐ No

Name of previous Dentist _____ City _____ State _____

The American Dental Association recommends, and our office requires, a current radiographic profile. Diagnostic information can be difficult or impossible to detect by oral inspection. Radiographs can show decay, gum disease, abscesses, impactions, missing teeth, future crowding, cysts, tumors, and TMJ problems. Your dental examination is considered complete only when your pictures have been reviewed by the Doctor. Please advise us of contraindications to necessary radiographs.

PAYMENT

- Questions about treatment and fees are encouraged before treatment begins.
- Full fees for the entire procedure are incurred at the preparation visit for fixed prosthetics, impression date for removable prosthetics, and initial treatment for endodontic and soft tissue therapy.
- Payment in full, by cash, credit card, or check, is required when services are rendered.
- Returned checks will be subject to a $15.00 charge.
- Insurance and/or credit arrangements must be made in advance.
- A service charge of 1.25% (15% APR) will be applied to all accounts for which the amount due now is not received within 15 days of the billing date.
- When appointing, please choose your time carefully. Fees will be incurred for missed appointments.
- I understand (regardless of insurance) that I am responsible for all costs of dental treatment.

I agree to all the above terms.

Signature: _____ Date: _____ (Valid for Five Years)

Do you have Dental Insurance? ☐ Yes ☐ No

If yes, please provide our receptionist with a copy of your insurance benefits booklet and complete the reverse side of this form. If your insurance is current and recorded on a family member's account, sign the permission and/or assignment areas only.

DENTAL INSURANCE

As a service to our patients, we will complete a standard insurance form. You must complete our questionnaire below. If you choose to pay us in full or assign your benefits, we will release your information to your carrier.

As a courtesy, we will accept most assignments of benefits and wait up to six weeks for payment from your insurance company. You must first pay your yearly deductible and copayments.

To determine these fees, it is essential that we have a copy of your benefit plan booklet. Unless shown to the contrary, your estimated yearly deductible will be $50.00, and your copayments will be 20% of routine and 50% of major treatment. Your deductible is due at your first visit, or first visit of the new year, and copayments are to be made at each office visit. When insurance payment is received, your family account will be credited accordingly. Any positive balances will be refunded at our next billing period.

Please be aware that your insurance is a contract between your employer and his or her carrier. Our office is not party to that contract. In the event of claim underpayment, rejection and /or delayed processing (more than six weeks), the amount submitted becomes immediately payable by you. Upon your payment in full, a new claim form will be given to you and your insurance company can reimburse you directly.

Deductibles, copayments and maximums are, at best, confusing and vary greatly according to the employer's contributions to your plan. Please bring in your insurance booklet, a copy of which can be obtained from your employer, and let us help you interpret your benefits before treatment begins.

PERMISSION TO FILE YOUR INSURANCE

I authorize my dentist to release to my insurance company(s), any information related to my family's dental office visits. I understand that my signature will be on file and a copy of this authorization will be used in all insurance submissions. Although my dentist will act as my agent to help me obtain insurance payment, I am still responsible to his or her office for any expenses incurred regardless of carrier coverage.

Signature _____ Date _____ (Valid for Five Years)

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to my dentist of the group insurance benefits otherwise payable to me or my family. I understand that my signature will be on file and a copy of this authorization will be used in all insurance submissions.

Signature _____ Date _____ (Valid for Five Years)

Enter N/A where not applicable

#1 Policy Holder's Name _____ (First, Middle Init., Last) S.S.# ___-___-___ Birth Date _____

Policy #1 covers: ☐ Self ☐ Child ☐ Spouse Your relation to holder: ☐ Self ☐ Child ☐ Spouse

Insurance Company Name _____ Street _____

City _____ State _____ Zip _____

Employer Name _____

City _____ State _____ Zip _____

Group Agreement# _____

Employee # _____

Enter N/A where not applicable

#2 Policy Holder's Name _____ (First, Middle Init., Last) S.S.# ___-___-___ Birth Date _____

Policy #1 covers: ☐ Self ☐ Child ☐ Spouse Your relation to holder: ☐ Self ☐ Child ☐ Spouse

Insurance Company Name _____ Street _____

City _____ State _____ Zip _____

Employer Name _____

City _____ State _____ Zip _____

Group Agreement# _____

Employee # _____

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