Patient Information

☐ New Patient

☐ Existing Patient ☐ Change of Information: ____________________

Date: ____________ Home Phone ____________ Cell Phone ____________

Name: ____ Social Security #: ____-____-____
Last Name First Name Middle Initial

Address: ____ E Mail ____________________

City: ____________________ State ____________ Zip ____________

Sex: ☐ Male ☐ Female Birthdate: ____________

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

Who is Responsible for this Account

☐ Same as above

Relationship to Patient: ____________________

Name: ____ Social Security #: ____-____-____
Last Name First Name Middle Initial

Address: ____ E:Mail ____________________

City: ____________________ State ____________ Zip ____________

Home Phone ____________ Cell Phone ____________ Birthdate: ____________

Insurance Information

Relationship to Patient: ____________________

Primary Insurance Carrier:

Insurance Carrier: ____________________

Insurance Address: ____________________

Policy #: ____________ Group #: ____________

Employer: ____________________

Relationship to Patient: ____________________

Secondary Insurance Carrier:

Insurance Carrier: ____________________

Insurance Address ____________________

Policy #: ____________ Group #: ____________

Employer: ____________________

Whom may we thank for referring you to our practice? ____________________

What appealed to you about our practice in regard to your oral health? ____________________

Which of the following are important to you? ☐Appearance ☐Comfort ☐Health ☐Preservation of teeth Other ____________

What would you like us to know about your past dental-related expriences: ____________________

Are you happy with your smile? ☐Yes ☐ No-What would you like to change about it? ____________________

Our Financial Policy

Patient Name: ______________________ Date: ____________

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

Fees less than $300 are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards (MC, Visa, American Express, and Discover).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment Options

☐ **Total Treatment Estimate:** __________ **Insurance Estimate:** __________ **Portion Payment:** __________

☐ 1. ***Prepayment Courtesy:***
We are happy to offer a 5% accounting courtesy for all treatment over $500 that is paid in full prior to treatment commencing. $__________ (Discount) $__________ (Adjusted Total) __________ (Must Be Paid By)

☐ 2. ***Payment as Services are Rendered:***
If you wish to pay the estimated amount for treatment at the time services are rendered, we gladly accept cash, personal checks, and most major credit cards. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may be owed.

☐ 3. ***Monthly Payment Plans:***

☐ **"Same As Cash" Interest-Free Credit Line**
Monthly Payments (up to 12 months) interest free — $__________ Monthly Total

☐ **Extended Payment Plan**
For treatment plans between $1,500 & $25,000 — Range. $________ to $________
18-60 months duration
No down payment required
Payments as low as $59 a month
No pre-payment penalty

☐ **3 Equal Monthly Payments**
25% initial down payment — $__________ Down Payment $__________ 3 Monthly Payments
Guaranteed with major credit card

☐ **"Lay-Away" Plan**
Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

I, ______________________, understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature: ______________________ Date: __________

Financial Coordinator Signature: ______________________ Date: __________