Welcome! We are pleased to have you join our practice.

Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you to achieve lifelong dental health!

Name (Last, First) ______________________ Preferred/Nickname __________ Home Number ______________

Address ______________________________________ Work Number ______________

City, State, Zip ______________________________________ Call Number ______________

Email ______________________________________ Social Security Number ______________

Employer ______________________ May we contact you at work? Yes ☐ No ☐ Date of Birth __________ Age ______

Whom may we thank for referring you? ______________________+________ Male/Female Marital Status __________

Emergency Contact (Name and Phone Number) ______________________________________

Person Responsible for Account (if different from above) ______________________ Home Number ______________

Address ______________ City, State, Zip ______________ Work Number ______________

Employer ______________________________________ Cell Number ______________

SS Number ______________ Date of Birth ______________ Age ______________ Male/Female

Primary Dental Insurance Policyholder (if different from above) ______________________ Insurance Company ______________

Policyholder Address ______________ City, State, Zip ______________ Home Number ______________

Employer ______________________________________ Work Number ______________

SS Number ______________ Date of Birth ______________ Cell Number ______________

Financial Policy

We ask that full payment be made at the time of service unless other written arrangements have been made. Cash, personal check, Visa, Master Card and Discover credit cards accepted.

For cash or check payment prior to an appointment, a 5% discount will be given. If you have insurance and you pay in full prior to your appointment in order to receive the 5% discount, we will have the insurance company reimburse you directly.

For master treatment plans that total over $250 you may choose to finance with Citi Health upon credit approval. This is usually a 0% interest loan for up to 6 months.

If you have insurance we will help you file your insurance claim. We are not contracted with your insurance company but will act to help you receive maximum benefits. We will ask you to pay the estimated portion not covered by your insurance at the time of service. You are responsible for charges not covered by your insurance company.

After insurance has paid we will bill you for any remaining balance, due within 30 days. For outstanding insurance claims over 60 days, we ask that you become fully responsible for the balance, even if your insurance company has not made a decision. If your balance is not paid within 90 days of the time of treatment,a finance charge will be applied.

If you are covered by a secondary insurance, we will submit to both your primary and secondary insurance but ask that you pay your primary out of pocket at the time of service. Your secondary insurance benefit will be sent to you directly for reimbursement.

For patients who are on a cash only basis, we ask that you pay for the appointment in cash prior to the appointment.

I have read the above financial policy and by my signature agree to the terms. My signature also authorized the Insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions.

Signature ______________________________________ Date ______________