



# 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 are glad to help you. We look forward to working with you to achieve **lifelong dental health!**

## Patient Information

Name \_\_\_\_\_ Preferred or Nickname \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
City State, Zip \_\_\_\_\_ Home Number \_\_\_\_\_  
Employer \_\_\_\_\_ May we contact you at work?  Yes  No Work Number \_\_\_\_\_  
Email \_\_\_\_\_ Cell Number \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_  Male  Female  
Whom may we thank for referring you? \_\_\_\_\_ Emergency Contact and Phone Number \_\_\_\_\_  
How would you like us to remind you of appointments? (may choose more than one)  email  text  phone call-home, work, cell

## Responsible Party (If different than patient)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone Number \_\_\_\_\_  
Employer \_\_\_\_\_ SS Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Dental Insurance Policyholder (If different than patient)

Policyholder Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ SS Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Insurance Company Phone Number \_\_\_\_\_

## Financial Policy

We ask that full payment be made at the time of service unless other written arrangements have been made. If your balance is not paid within 60 days of the time of treatment a billing charge may apply and if not paid after 90 days of the time of treatment, a finance charge may apply. Cash, personal check, Visa, Master Card and Discover credit cards accepted.

3, 6 and 12 months 0% financing payment plans available, with approved credit. After your first appointment, you may be eligible for a 5% pre-paid discount. Please ask us for details.

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

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. You are responsible for charges not covered by your insurance company.

**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 \_\_\_\_\_