# Patient Information Form

**Today's Date** _____

**Patient Name:** First _____ MI ___ Last _____ Nickname _____

**Address:** Street _____ City _____ State _____ Zip _____

**Phone:** Home _____ Work _____ Mobile _____

**E-mail address** _____

**By providing your e-mail address you agree to receive** *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

**What is your preferred method of contact?** ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-mail

**Social Security Number** _____ **Date of Birth** _____

**Driver's License No.** _____ **State of Issuance** _____

**Patient Employed By** _____ **Occupation** _____ **Phone** _____

**Employer's Address:** Street _____ City _____ State _____ Zip _____

**Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

**In case of emergency, who should be notified?** _____

**Relationship to Patient** _____ **Home Phone** _____ **Mobile Phone** _____

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**Is the patient a Minor?** ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

**Name of Responsible Party:** First _____ Last _____

**Date of Birth** _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other

**If patient is a Minor, primary residency** ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

**Address:** *(if different from patient)* Street _____ City _____ State _____ Zip _____

**Phone:** Home _____ Work _____ Mobile _____

**Employer:** _____ **Occupation** _____ **Phone** _____

**Employer's Address:** Street _____ City _____ State _____ Zip _____

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## Dental Benefit Plan Information

**Primary Dental Plan Name** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

**Name of Insured** _____ **Date of Birth** _____ **ID Number** _____

**Policy Number** _____ **Patient Relationship to Insured** _____

**Secondary Dental Plan Name** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

**Name of Insured** _____ **Date of Birth** _____ **ID Number** _____

**Policy Number** _____ **Patient Relationship to Insured** _____

**Whom may we thank for referring you?**

☐ One of our valued patients *(name of patient)* _____

☐ Advertisement _____ ☐ Local Dental Society _____

☐ Our Web site ☐ Other _____

**Please list other members of your immediate family who are patients in our practice**

_____ _____ _____ _____

**Patient Responsibilities:** We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment cash, checks or credit cards.
* *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

**Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

**If we are a contracted provider with your plan**, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

**If we are not a contracted provider with your dental benefit plan**, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

**Scheduling of Appointments:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 24-hour notice to reschedule an appointment. With less than 28-hour notice, a fee or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee or deposit to reserve the appointment time again, may be required.

**Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (**initial**)

I have read the above and agree to the financial and scheduling terms. _____ (**initial**)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (**Circle One**) _____ (**initial**)

I hereby acknowledge that a copy of this practice's *Notice of Privacy Practices* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (**initial**)

I hereby acknowledge that a copy of this practice's *Dental Materials Fact Sheet* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (**initial**)

**Signature** _____ **Date** _____