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Patient Information Form

Today's Date _____

Patient Name *first* *MI* *last*			Date of Birth
Address *street*		*city*	*state* *zip code*
Check best way to reach you ☐ Home ☐ Work ☐ Mobile ☐ Email	Home Phone ( )		Work Phone ( )
Mobile Phone ☐ Call ☐ Message ( )		Email Address	
Social Security #		Drivers License #	State
Employer Name	Occupation		Phone ( )
Emergency Contact Name	Home Phone ( )	Cell Phone ( )	Relationship to Patient

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 code*

Dental Benefit Plan Information *(Please present insurance cards to receptionist)*

PRIMARY Dental Plan Name	**SECONDARY** Dental Plan Name
Phone ( )	Phone ( )
Claims Address *street*	Claims Address *street*
city *state* *zip code*	*city* *state* *zip code*
Subscriber Name / Date of Birth	Subscriber Name / Date of Birth
Relationship to Insured ☐ self ☐ spouse ☐ child ☐ other _____	Relationship to Insured ☐ self ☐ spouse ☐ child ☐ other _____
Policy / Group # / ID #:	Policy / Group # / ID #:

Medical Plan Information *(Please present insurance cards to receptionist)*

Medical Plan Name			Phone ( )
Claims Address *street*		*city*	*state* *zip code*
Subscriber Name	Date of Birth	Relationship to Insured ☐ self ☐ spouse ☐ child ☐ other _____	
Policy / Group #	ID #		Deductible Amount

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 practive.

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**, **Check**, **Visa**, **M.C.**, **Amex**, **Discover**, **CareCredit**, and **CitiHealth**. 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. Our practice ☐**IS** ☐**IS NOT** a contracted provider with your dental benefit plan.

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 48-hour notice to reschedule an appointment. There will be absolutely no charge for any cancellations so long as we get a 48-hour notice.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
My email address is _____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.
My email address is _____

☐ I Do Not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

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 _____ (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: _____