Whom may we thank for referring you to our practice?

A patient   A dentist or physician   Website   Phonebook   Employee   Insurance

Did our website influence your decision to call our office?__________________________

Name of person, office, or company referring you to our practice___________________________________

Insurance Information

Primary

Name of Insured:________________________________

Address:_____________________________ City_____________________State_____Zip_____________

Phone (Home):_________________(Work) _________________Ext_____Relationship to Patient__________

Social Security#___________________Insurance ID#_________________Birthdate____________________

Employer Name____

Insurance Plan Name Address/Phone:____

____Group#______________________________

Secondary

Name of Insured:________________________________

Address:_____________________________ City_____________________State_____Zip_____________

Phone (Home):_________________(Work) _________________Ext_____Relationship to Patient__________

Social Security#___________________Insurance ID#_________________Birthdate____________________

Employer Name____

Insurance Plan Name Address/Phone:____

____Group#______________________________

Consent for Services & Financial information- PLEASE READ CAREFULLY

This office accepts cash, checks, major credit cards, and Care credit (a third party financing service).
A service charge of 1.5% per month (18% annum) on unpaid balances will be charged to my account if not paid within thirty days plus a billing fee of $2.50 per statement. I understand this office does not routinely send statements or bills and I accept full responsibility for me or for any of my immediate family. If it becomes necessary to turn an account over to a collection agency for payment, 33% of the balance will be added to your account. I understand that any fee estimates for dental services will only be extended for a period of six months from the date of the estimate. For our patients over the age of 60 who do not have dental insurance we offer a courtesy discount of 15%.

Insurance Patients: Your dental insurance is a contract between your employer and the insurance company they have chosen. We are a third party and we file your dental insurance as a courtesy to you our patients; **however you are ultimately responsible for all fees for dental services**. We will be glad to accept assignment of benefits for dental services and we will expect you to pay your estimated portion of the dental services at the time of service.

I agree to keep all scheduled appointments unless I notify the office at lease 48 hours prior to the appointment.
I understand that a failure to keep scheduled appointments may result in a missed appointment fee charged to my account and I may be asked to hold future appointments with a credit card.

I have read the above conditions of treatment and payment and agree to their content and I hereby give my consent for treatment for me or for the above-named patient.

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Signature of patient, parent or guardian or responsible party   Date   Relationship to Patient

Notice of Privacy Practices as required by HIPPA

We may use your health information for two primary purposes: Treatment and payment.

Treatment: We may disclose your health information to another dentist or physician providing treatment to you.

Payment: We may disclose your health information to obtain payment for services we provide to you (e.g. insurance company)

Other: It is unlikely, but we may be asked to disclose your health information as required by law for disaster relief; to report abuse or neglect; for public health statistics; by court order; to law enforcement agencies; to coroners, medical examiners; organ procurement organizations; to avert a serious threat to health or safety; to federal officials for national security and as authorized by state worker’s compensation laws