Dr.Z Dentistry

Patient Information Form

Date_____

Name_____
Last First Middle Initial

SS#_____ DOB_____ Sex_____

Home Phone_____ Cell Phone_____

Email_____

Address_____
Street

_____
City State Zip

Child_____ Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Emergency contact_____ Phone_____

Employer_____

Business Address_____

Occupation_____ Business Phone_____

Reason for today's visit _____

Previous Dentist_____ Date of last exam_____

Phone _____ Date of last X-rays _____

Address _____

I allow the following individuals to discuss my financial, medical and/or dental information with employees of Dr. Z Dentistry.
Print full names_____, _____

Who should we thank for referring you? _____

INSURANCE INFORMATION

Subscriber Name_____ SS#_____

Relationship to patient_____ Subscriber's Birthdate_____

Address_____ Home Phone_____
Street

_____
City State Zip

Employer_____ Date employed_____

Business Address_____ Work Phone_____
Street

_____
City State Zip

Insurance Company Name_____

Group #_____ Subscriber ID#_____

Ins Co Address_____
Street City State Zip

Ins Co Telephone # _____

It is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate is based on information provided by you and your insurance company. Please remember that it is only an estimate and your benefits may be higher or lower than what is estimated. In all cases, the cost of all dental care is ultimately the responsibility of the patient or their legal guardian, regardless of insurance coverage. Therefore, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement. We encourage all patients to refer to their member handbooks or call their plan administrator with any questions or concerns relating to specific benefits.

I hereby authorize payment directly to Dr. Z Dentistry, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party_____ Date_____

PATIENT AGREEMENTS

Financial Responsibilities:

Payment in full of the estimated patient portion is due at the time of treatment! Please do not hesitate to ask for a pre-treatment estimate. The Treatment Plan Estimate is a good faith attempt to predict the costs of your treatment based on the information known at the time of the estimate.

Accepted Forms of Payment:

Dr. Z Dentistry accepts cash, personal checks, Visa, Mastercard, Discover, assigned insurance benefits and approved third-party financing.

Third Party Financing:

Dr. Z Dentistry offers treatment financing through CareCredit. Dr. Z Dentistry pays this company fees for making loans available to patients and for the lender's cost of servicing these loans.

Collection Policy:

If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, 33 1/3% attorney fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

Missed Appointments/Cancellation Policy:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least 2 business days notice for cancellations or rescheduling of your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment, however, a charge may be assessed for multiple missed or short notice cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

X-Rays:

We pride ourselves in delivering the highest standard of care; therefore complete diagnostic x-rays are required for our new patients. If you have had this series in the past three years, we ask that you bring them with you on your initial visit. If you do not have them or are not able to retrieve them from your prior dentist before your appointment with us, we will need to take X-rays and charge accordingly.

Patient Authorization:

I agree to and understand the above statements. Furthermore, I understand that it is my responsibility to inform this office of any changes to the information I have provided. I, the undersigned do hereby fully authorize to examine, to treat and to care for me as decided upon and deemed necessary. I realize and adopt the risks involved.

Signature_____ Date_____