

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/DL# _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/DL# _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at the time of service. A statement will be sent when a balance is due and 30 days after that statement is sent I will be assessed a late fee each month until the account is paid. After an account is 90 days past due it will be turned over to a collection agency. I agree to pay all collection agency costs and attorney fees.

X

Signature of patient (or parent/guardian if minor) _____ Date _____

Preston Family Dental has established a missed appointment policy. If a cancellation is made without 24 hours notice it will be at the offices discretion whether a missed appointment fee will be added to your account. This policy will also include patients that fail to keep their appointments without notifying our office. The missed appointment fee is \$50.00. The fee will be charged to your account and must be paid before another appointment can be scheduled.

A broken appointment affects three people:

- (1) The dentist or hygienist whose time was reserved for your visit,
- (2) Another patient who is awaiting an appointment to receive needed dentistry and
- (3) You, because your dental needs have not been met.

Thank you for your cooperation with this matter. If you have any questions feel free to contact us at 732-7874.

I have read and understand the missed appointment fee policy.

Patient (guardian)

Over Please

date

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

SS#/DL# _____
Date _____
Name _____ Birthdate _____
Home Phone _____ Cell Phone _____
Address _____
City _____ State _____ Zip _____
Email _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ Full Part
City _____ State _____ Time Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____
City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____
Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____
Home Phone _____ Cell Phone _____
Email _____
Driver's License# _____ Birthdate _____
Employer _____
Work Phone _____ SS#/DL# _____
Is this person currently a patient in our office? Yes No
Full payment due at time of service. For your convenience, we offer the following methods of payment.
• Cash • Personal Check • Care Credit • Discover • MasterCard • VISA