HOA _______________ **DENTAL ASSOCIATES, P. C.** Chart Number_____________

PATIENT INFORMATION

Today's Date _______________________________ Dentist you wish to see ____

Patient Name ____
Last First MI (Preferred Name)

Martial Status: Single Married Other Sex: Male Female

Address ____ Apt # ______________

City ____ State _________________ Zip Code ______________

Home phone ________________________ Work phone _______________________ Cell phone _______________________

Where would you prefer to be contacted? Home Phone Work Phone Cell Phone

Employer ____

Social Security Number ___________________________________ Date of Birth ____________________ Age ______________

E-Mail Address ____

Spouse's Name (or Parent/Guardian) ____

Are you a FULL time college student? If so, name of college _________________________________ Hours Enrolled __________

Please list family members who are patients at Dental Associates ____

Whom may we thank for referring you to our office? ____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

If patient is a minor or someone other than the patient is responsible for payment of the account, please provide the following information.

Guarantor's Name ____

Guarantor's Social Security Number ____

Guarantor's Address ____

Guarantor's home phone _____________________work phone ______________________ cell phone ______________________

Guarantor's Employer _________________________________ Relationship to patient __________________________________

PRIMARY DENTAL INSURANCE INFORMATION

Policyholder's Name __________________________________

Policyholder's Date of Birth ____________________________

Policyholder's ID ______________________________________

Policyholder's SSN ____________________________________

Policyholder's Group #_________________________________

Policyholder's Employer ________________________________

Insurance Company ____________________________________

Policyholder's Signature ________________________________

SECONDARY DENTAL INSURANCE INFORMATION

If you have double insurance coverage, complete this for the second coverage.

Policyholder's Name __________________________________

Policyholder's Date of Birth ____________________________

Policyholder's ID ______________________________________

Policyholder's SSN ____________________________________

Policyholder's Group #_________________________________

Policyholder's Employer ________________________________

Insurance Company ____________________________________

Policyholder's Signature ________________________________

OVER

Financial Guidelines

In an effort to keep dental fees down, while maintaining a high level of professional care, we have established the following plans of payment for the use of our patients:

1. Payment in full for each visit is due unless other financial arrangements are made in advance. We accept the following debit/credit cards: VISA, MasterCard, Discover, and AMEX.
2. We will gladly accept payments from dental insurance companies. Current insurance information must be provided at each visit. The patient (guarantor) will be asked to pay the portion not covered by insurance at the time of the visit. The patient (guarantor) is responsible for any unpaid insurance claim after 90 days from the date of service.
3. Returned checks will be assessed a $25.00 fee.
4. Interest free financial arrangements may be made for 6 months for qualified applicants through a third party financial institution.
5. The adult accompanying a minor and the parent and/or guardian of the minor is responsible for full payment.

Office Insurance Policies

You are responsible for payment of your account even though you may have insurance. Your insurance contract is an agreement between *you and your insurance carrier*. In the event your insurance pays you directly, payment will be due at time of service. While we cannot negotiate a settlement of your claim with the insurance company, we will, within our limits assist you. If you provide proper information, we will file with your insurance. Payments made directly to us by your insurance company will be applied to your account and any overpayment will be refunded.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates. PLEASE CHECK WITH YOUR INDIVIDUAL INSURANCE PLAN TO DETERMINE IF WE ARE A PARTICIPATING PROVIDER.

We will file an initial claim with your insurance carrier. If you have secondary insurance, a claim will be filed with that carrier also, provided we have the necessary information (i.e. primary explanation of benefits, if payments are made to you). If payment is not received from your insurance company with 90 days, please remit balance promptly.

Authorization for Signature on File, Payment and Release of Information

I hereby authorize the office of DENTAL ASSOCIATES, P.C. to affix my name to any and all claims or documents as related to any and all dental benefits due to my dependents and me.

I hereby authorize the payment of dental benefits directly to the office of DENTAL ASSOCIATES, P.C. I authorize release of any information relating to this claim.

This "Signature on File" will be valid from this date and shall expire in one year.

I have read and understand the financial guidelines and office insurance policies. I also understand that I am responsible for my balance regardless of my insurance.

DATE	PATIENT SIGNATURE (Parent/Guardian of Child)
DATE	PATIENT SIGNATURE (Parent/Guardian of Child)
DATE	PATIENT SIGNATURE (Parent/Guardian of Child)
DATE	PATIENT SIGNATURE (Parent/Guardian of Child)