New Patient Information

PATIENT # _____

NAME _____ EXAM DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT D.O.B. _____ CONFIRMATION PHONE # _____ GENERAL DENTIST _____

INSURANCE COMPANY _____ PHONE # _____ GROUP# _____

POLICY HOLDER _____ SOCIAL SECURITY # _____

I D # _____

PLACE OF EMPLOYMENT _____ POLICY HOLDER'S D.O.B. _____

If you have dual coverage, please ask for an additional form

RELATIONSHIP TO PATIENT _____

IS THIS A REFERRAL? YES NO

IF YES, WHO? FAMILY FRIEND DENTIST

NAME: _____

HAS PATIENT HAD PRIOR ORTHO TREATMENT? YES NO

RESPONSIBLE PARTY'S NAME AND ADDRESS IF DIFFERENT FROM PATIENT:

_____

_____

_____

Please note that we will file your insurance as a courtesy to you. Make sure that all information is correct so as not to delay the processing of your claim. If for any reason your insurance should change or be terminated you will need to notify us ASAP. We will be happy to file a claim with your new carrier. Because orthodontic treatment is comprehensive, any benefit that you receive from your insurance company is only in effect as long as you maintain that coverage. The patient's financial responsibility will change according to the benefits of the new carrier. Any portion refused payment by insurance will become the responsibilty of the patient.

please initial _____

Payment Information

Payment Policy

Payment for today's visit and your future visits are are due at the time of treatment

Payment Options

- Cash – includes money orders and personal checks
- Credit Card – to include Visa, Master Card, American Express and Discover.
- Dental Payment Plan – a separate line of credit that is offered to cover your entire family's dental care needs.
  - A credit line may be established and approval usually takes less than 10 minutes.
  - No payment is needed today to start treatment.
  - Dental Payment Plan is 90 days same as cash on treatment greater than $300.
  - There is no annual or membership fee.

It is Your Responsibility to pay your estimated portion of services at the time you receive them, regardless of any dental insurance benefits. We will provide monthly statements on accounts that have a balance.

Unpaid account balances greater than 61 days will be charged a finance charge of 1.75% per month (21% APR).

In the event of non-payment, you will be responsible for any collection and or legal fees associated with the collection of the balance due. The collection fee is 21% of the total balance turned over to an outside agency.

By signing below, I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefit to be paid directly to the Dental Practice. I also authorize the doctor to release to my insurance carrier(s), any information required to process any claim(s). I understand that by signing this, I may be charged a fee for missing or not giving adequate notice (24 hours in advance) for canceling an appointment.

X _____ X _____

PATIENT'S NAME (Please Print) DATE

X _____

NAME OF RESPONSIBLE PARTY (Please Print)

X _____

SIGNATURE OF RESPONSIBLE PARTY