PALOLA DENTAL

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Home Address:	Social Security no.:	Contact Numbers: H: C:

Occupation:	Employer:	Employer phone no.:	
Driver's License #:		Email Address:	
Whom may we thank for referring you to our office?			

SPOUSE INFORMATION -OR- GUARDIAN INFORMATION, IF A MINOR

Last name:	First:	Middle:

Date of Birth:		Employer:		Work no:	

Email Address:	Social Security no.:	Contact Numbers: H: C:

Contact Numbers:	Home:	Mobile:	Email Address:

RESPONSIBLE PARTY

Name:		Birthdate:		Social Security No.	
Address: (if different from above)		Contact Number:		Driver's License #:	

EMERGENCY CONTACT

Name:		Contact Number:	
Relationship:			

INSURANCE INFORMATION

Primary Insurance Company Name:			
Primary Subscriber:		Birth date: / /	Social Security No.
Subscriber ID #:		Group#:	
Address:		Phone #:	
Relationship to Subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Secondary Insurance (if applicable):			
Primary Subscriber:		Birth date: / /	Social Security No.
Subscriber ID #:		Group#:	
Address:		Phone #:	
Relationship to Subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		

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Financial Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, Discover, and JCB.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Late Cancellations/ Missed Appointments: We reserve Doctor's time exclusively for you, and with late notice we may not be able to offer it to any of our patients on standby. Should you require rescheduling, please contact our office 48 hours prior to your reservation to avoid being charged a late cancellation fee of $50.

Rescheduling Appointments: If you miss or cancel a reservation late, we may require a deposit of 1/3 of the payment for that day's treatment in order to reschedule.

Do you have insurance?

- As a courtesy to you, we will help process your insurance claims. Please understand that we will provide an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract among you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay the deductible and co-payment which is the estimated amount not covered by your insurance company via cash, check, or credit card at the time we provide treatment.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial guidelines.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial agreements have been made. I further understand that a finance, rebilling, collection charge, or attorney fee will be added to any overdue balance. I have read and agree to the HIPAA guidelines.

Patient/Guardian Signature: _____ Date: _____