

BLAIR RIDGE DENTAL

Welcome! and thank you for selecting our office. It is our intention to make your visits with us as pleasant as possible. Please assist us by reading and completing the following material. If you have any questions, please feel free to ask for assistance.

PATIENT INFORMATION

Patient name _____ Birth Date _____ Age _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Social Security # _____
Employer _____ Occupation _____
Employer City _____ Work Phone _____
____ Male ____ Female Preferred Title ____ Mr. ____ Mrs. ____ Ms. ____ Dr.
Referred By: _____
Last Dental Visit _____ /By Whom _____

RESPONSIBLE PARTY (if other than patient)

Name _____ Relationship to patient _____
Address _____ Birth Date _____
City _____ State _____ Zip _____ Social Security # _____
Employer _____ Work Phone _____
Employer Address _____ City _____ St. _____ Zip _____

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

If you have dental insurance, we will be glad to submit your claim for you. Dental insurance is not meant to be a pay-all; it's only meant to be an aid.

Many plans tell you you'll be covered "up to 80-100%." The amount your plan pays is determined by how much your employer paid for the plan.

Many routine dental services are not covered by dental insurance at all.

If you have any questions regarding your insurance, please contact us and we will help in any way we can. We are happy to help submit your claims, and we will try to get the maximum benefits that your plan provides.

PRIMARY DENTAL INSURANCE

Name of Person who has insurance _____ Birth Date _____
Relationship to patient _____ Insurance Company _____
Insurance Company Address _____
Employer _____ City _____
Social Sec. Number _____ Policy # (if other than SS) _____ Group # _____

SECONDARY DENTAL INSURANCE

Name of Person who has insurance _____ Birth Date _____
Relationship to patient _____ Insurance Company _____
Insurance Company Address _____
Employer _____ City _____
Social Sec. Number _____ Policy # (if other than SS) _____ Group # _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and treatment or examination rendered to me or my child during the period of such dental care to third party payers (insurance company) and/or other health practitioners.

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.

X _____ Date _____
Signature of Patient or Parent if minor.

ADDITIONAL INFORMATION

Other than the names above, whom may we contact in case of emergency?

Name _____ Phone Number _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment expected at each appointment.

- _____ Cash
- _____ Personal Check
- _____ Credit Card _____ Visa _____ Master Card _____ Discover
- _____ Insurance (We will file your insurance claims for you, and we will ask for your estimated portion due at the time of service.)
- _____ I wish to discuss the office's policy for payment arrangements.

LATE CHARGES

If the entire balance is not paid within 60 days from the date of service, 1-3/4% monthly interest charge will be added to my balance. I understand that all collection costs and attorney fees incurred will be billed to me in attempting to collect on this account or any future outstanding balances.

I understand that I may be charged for appointments which I fail to keep and for appointments cancelled with less than 24 hours notice.

I have read and fully understand the financial agreement.

Signature _____ Date _____

ADDITIONAL NOTES AND COMMENTS

Thank you for filling out this form completely. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.