SOUTH WATERFRONT DENTAL, LLC

PATIENT INFORMATION

DATE _____

NAME _____ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST M ❑ DOMESTIC PARTNER

ADDRESS _____
STREET APT# CITY STATE ZIP

TELEPHONE _____ _____ _____ _____
HOME # WORK # CELL # **EMAIL ADDRESS**

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____
MONTH DAY YEAR

PLACE OF EMPLOYMENT _____ WORK ADDRESS _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN THIS OFFICE? ❑ YES ❑ NO _____

HOW DID YOU FIND OUR OFFICE? ANYONE WE CAN THANK? _____

DENTAL INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED

LAST NAME | FIRST NAME | M

STREET | CITY | STATE | ZIP

HOME # | WORK # | CELL/PAGER #

BIRTHDATE (MO/DAY/YEAR) | RELATIONSHIP TO PATIENT

EMPLOYER | DENTAL INS. CO./ADDRESS

SOCIAL SECURITY NUMBER | SUBSCRIBER NUMBER | GROUP NUMBER

SECONDARY INSURED (IF DIFFERENT THAN PRIMARY)

LAST NAME | FIRST NAME | M

STREET | CITY | STATE | ZIP

HOME # | WORK # | CELL/PAGER #

BIRTHDATE (MO/DAY/YEAR) | RELATIONSHIP TO PATIENT

EMPLOYER | DENTAL INS. CO./ADDRESS

SOCIAL SECURITY NUMBER | SUBSCRIBER NUMBER | GROUP NUMBER

AUTHORIZATION

I hereby authorize payment directly to South Waterfront Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize South Waterfront Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals

FINANCIAL AGREEMENT & CANCELLATION POLICY

In order to assist you in making payments for your dental treatment, several options are available. Payments may be made by cash, check, credit card (VISA, MasterCard or Discover) or Care Credit. We reserve the right to charge a $25.00 fee for all checks returned for non-sufficient funds. Unless other arrangements have been made, **your balance is due at the time services are rendered.**

If you have dental insurance, as a courtesy, we will bill your insurance carrier directly. Dental insurance rarely covers 100% of services rendered; therefore please be prepared to pay your co-pay at each visit. South Waterfront Dental is happy to provide an estimate for your co-pay prior to your visit. This is an estimate only and you will be responsible for any amounts not reimbursed by your dental insurance.

Scheduled appointments are reserved specifically for you. If you need to change an appointment, please contact the office with at least 48 hours notice. **There will be a $25.00 fee for appointments cancelled without 48 hour notice. There will be a $50.00 fee for not showing for a scheduled appointment.**

We realize that time is very important to you, and we make every effort to stay prompt. We ask that you have the same consideration by being on time for your appointments.

Please do not hesitate to ask any questions you may have concerning office policies. We welcome open communication with you and wish to develop a relationship of friendship and trust. Our goal is to meet your dental needs while offering you the most comfortable and enjoyable dental experience.

_____ _____ _____

 Patient/Guardian Signature | Relationship to Patient | Date