

Patient Information Form

Today's Date _____

Patient Name: First _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____

E-mail address _____

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____ Sex Male Female

Marital Status Married Single Divorced Separated Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Cell Phone _____

Patient Employed By _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Is the patient a Minor? Y/N _____ Full-time Student Y/N _____ If yes, Name of school _____

Name of Responsible Party: First _____ Last _____

Relationship to Patient: Parent Other Date of Birth _____ Social Security #: _____

If patient is a Minor, primary residency Both parents Mom Dad Step Parent Shared Custody Guardian

Address: (if different from patient) _____

Phone: Home _____ Work _____ Cell _____

Employer (if different from above) _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Name of Insured _____ Date of Birth _____ ID Number _____

Relationship to Insured _____

Medical Plan Information

Plan Name _____ Phone _____

Name of Insured: _____ Date of Birth _____ ID Number _____

Group Number _____ Patient Relationship to Insured _____

Whom may we thank for referring you?

One of our valued patients (name of patient): _____

Advertisement: _____ Local Dental Society _____ Our Web site _____ Other _____

Please list other members of your immediate family who are patients in our practice

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment for dental services must be received on or before the day of the scheduled appointment, before services are performed. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice.

Forms of Payment: We accept the following forms of payment. Visa, Mastercard, Discover, American Express, Cash and Care Credit. If you elect to apply for third party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice. **Personal checks will not be accepted.** _____ (initial)

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice may or may not be a contracted provider with your dental benefit plan. Please inquire with our front office staff for more information regarding our participation with your insurance plan.

As a courtesy to you, Pries Dental Care will file claims on your behalf if you "assign benefits" to us. In this circumstance, you are responsible for your estimated patient portion at the time of service, and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If you choose not to "assign benefits" to us, we cannot file claims on your behalf, and payment for services will be due in full to our office on or before the scheduled appointment date.

Scheduling of Appointments: We reserve our time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 2 business days' notice to reschedule an appointment. With less than 2 business days' notice, a fee of \$25.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$50.00 or deposit to reserve the appointment time again, may be required. In addition, patients who arrive to their appointment unable to make payment will not be seen, and will be charged a failed appointment fee of \$50.00. Patients who fail to show to their appointment on more than 2 occasions may be asked for a deposit to reserve future appointments.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____(initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date _____

Print Name _____

*If not signed by the patient, please indicate relationship: _____