Collier Dental Studio

Patient Name_____ Birthdate_____ Age_____
Marital Status: Single__ Married__ Divorced __Widowed__ SS#_____ DL#_____
Home Address _____City_____ Zip_____
Home Number (____)_____ Cell Phone (____)_____
Email: _____ Best way to contact you: Cell ___ Home ___ Text
Employer Name and Address_____
Occupation _____Work # ( )_____

Person Responsible for Account_____ Relationship _____
Social Security # _____Birthdate _____ Home # ( )_____
Home Address (if different) _____ City _____Zip_____
Employer and address _____
Occupation _____Work # ( )_____
Referred By_____Physician_____
Emergency Information_____
(Name, Address, Telephone of a relative not living with you)

DENTAL INSURANCE INFORMATION (Primary)
Insured's Name: _____
Insured's DOB: _____
Insured's Employer: _____
Insurance Company: _____
Group# _____ Phone# _____

SECONDARY INSURANCE
Insured's Name: _____
Insured's DOB: _____
Insured's Employer: _____
Insurance Company: _____
Group# _____ Phone # _____

Financial Policy:

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 considered part of your treatment. Payment is due at the time service is provided. Our office accepts Cash, Amex, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Do You Have Insurance?

As a courtesy to you we will help you process all 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 ultimatelydetermine the amount paid. We will, of course, 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 between you, your employer, and your insurance company.

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 sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by Cash, Amex,
MasterCard, Visa or Discover at the time we provide the service to you.

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 policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

CONSENT:
The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's 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 the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance.

Patient Signature (Parent of Child) :_____ Date: _____