WELCOME

Thank you for selecting our dental health care team. We will strive to provide you with the best possible dental care. To help us meet all of your dental health care needs, please fill this form out completely in ink, ***both sides.*** If you have any questions or need assistance please ask us, we will be happy to help.

Patient Information (CONFIDENTIAL)

Date__________Social Security #_________________Home Phone_______________ Cell Phone____________________
Name__________________________________Pref. Name_______________________Birth Date_____________________
Sex __M __F Child[ ] Single[ ] Married[ ] Separated[ ] Divorced[ ] Widowed[ ] Email_________________________
Address______________________________City____________________State_____________Zip Code_______________
Patient's or Parent's Employer_____________________________________Work Phone__________________________
Business Address____________________________City___________________State___________Zip Code___________
Spouse or Parent's Name_______________________Employer_________________________Work Phone_____________
Business Address____________________________City___________________State___________Zip Code___________
If Patient is a Student, Name of School/College______________________City___________State________Zip__________
Whom May We Thank for Referring You____________________________Phone_________________
Person to Contact in Case of Emergency____Phone___________________

Responsible Party

Name of Person Responsible for this Account______________________________Relationship to Patient______________
Address__________________________City____________________State______Zip________ Email_________________
Birth Date_____________Social Security#___________________Home Phone_____________Cell Phone_____________
Driver's License________________Employer______________________________Work Phone___________________
Employer Address____________________________________City______________State_________Zip Code__________

Benefit Information

Subscriber Name________________________________Relationship to Patient____________Home Phone_____________
Subscriber Address______________________ City_______State__________Zip Code________Cell Phone______________
Birth Date______________Soc Sec #________________ Insurance ID#_______________Email___________________
Subscriber Employer_____________________________Work Phone_________________Date Employed______________
Employer Address______________________________City________________State_____________Zip_______________
Benefit Company_______________________________ Group #___________________Union or Local_______________
Ben Co Address_________________________________City________________State___________Zip_______________
Ben Co Phone__________________Yearly Deductible_______________Maximum Annual Benefit__________________

Does Patient have any **Additional Dental Benefits** Yes____No______ If Yes, Complete the Following:
Subscriber Name___________________________________Relationship to Patient______________________________
Subscriber Address_____________________City______State_________Zip Code________Home Phone______________
Birth Date__________________Social Security #________________________ Insurance ID#_______________________
Subscriber Employer_____________________________Work Phone_________________Date Employed______________
Employer Address______________________________City________________State___________Zip_______________
Benefit Company_______________________________Group #________________Union or Local__________________
Ben Co Address_________________________________City________________State____________Zip_______________
Ben Co Phone_________________Yearly Deductible__________________Maximum Annual Benefit_________________

Insurance Card If you don't have your insurance card or proof of insurance, you are expected to pay for your visit at the time of service.

Our office is filing insurance claims with an increasing number of insurance companies, therefore, it is impossible for us to keep a record of your personal insurance coverage. ***Please read your insurance contract to understand the benefits available to you.*** We will bill your insurance as a courtesy.
I understand that I am expected to keep my account current.

Canceled or Broken Appointments

I understand that when an appointment is made, this time is reserved especially for me. I understand a 24 hour notice is required for canceling appointments and that a $30-$50 charge will be made for broken appointments without suitable notice, according to the discretion of this office. Exceptions to this can be determined only on an individual basis according to circumstances. I grant my permission to your office to contact me at home or place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering machine or with family members or through texting or emailing. Yes [ ] No [ ] Initial ________

We try to remind patients by telephone prior to the appointment but please do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present.

Pre-authorization

Some insurance companies require pre-authorization for special procedures. We will pre-authorize with your benefit company. However, you are responsible to confirm your benefits as they do not tell us what benefits are available when we pre-authorize services. Pre-authorization is not a guarantee of payment. Payment is determined at the time a claim is submitted.

Office Policy on Payment and Authorization and Assignment Release

I understand that I am responsible for payment of services. I understand that payment is expected at the time services are rendered unless arrangements have been made. Copayments are due at the time of service. I realize that failure to keep this account current may result in my being turned over to **North American Recovery** and if this account is assigned to them for collections, I agree that in addition to any amount left owing to Dr. Wiest, I will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collection of any past due balance , and a collection fee of 40%. Furthermore, I agree that this fee is proportionate to the actual damage caused by my nonpayment and is not an excessive estimate of the costs of collection.

I, the undersigned certify that I (or my dependent) have benefits and assign directly to Dr. Gary Wiest all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by benefits. I hereby authorize Dr. Gary Wiest to release all information necessary including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or any health practitioners to secure the payment of benefits. I authorize the use of this signature on all benefit submissions.

I understand that there will be a $25 charge on all returned checks. I understand that ofter one returned check, the only acceptable method of payment is cash or credit card.

I certify that the above information is true and correct to the best of my knowledge. I give permission to Dr. Gary Wiest to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my oral health.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer.

______Payment in full at each appointment
______Cash
______Personal Check
______American Express
______Discover
______MasterCard
______Visa
______Care Credit (This is a health care card that can be registered for online @ carecredit.com)

I have read this financial policy and agree to the above.

Patient's Signature (Parent or Guardian if patient is a minor)____

Relationship____Date____