Date: _____

PATIENT INFORMATION

Mr.Ms.Dr.Rev. _____ Birthday _____SS #_____

Last First MI

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work (____)_____ Cell Phone (____)_____

E-mail _____ Place of Employment _____

Employer Address (school name if student)_____

Emergency Contact _____ Relationship to patient _____

Whom may we thank for referring you to our Office? _____

Primary Insurance:

Subscriber's full name _____ Birthday _____SS # _____

Insurance Co. _____Employer _____ Group # _____

Secondary Insurance:

Subscriber's full name _____ Birthday _____SS # _____

Insurance Co. _____Employer _____ Group # _____

FINANCIAL POLICY

As a convenience to our patients we will file pre-treatment estimates and dental claims for those patients who assign payment to this office. At the time of treatment you are required to pay all deductible amounts and any co-payments therein. Those fees not covered by insurance are also the responsibility of the patient. It is important for you to know that we work for you the patient 100% and likewise our services are charged directly to you. If your insurance company fails to make payment after sixty days of the proper filing of said claim, the patient becomes liable for the unpaid balance. Rest assured that we will work with you in pursuing your insurance claim.

If you do not have dental insurance at the time of treatment you are expected to make payment at the time of treatment. If in the event that treatment requires multiple appointments, and/or the utilization of a commercial laboratory, then one-half of the total treatment fee is due at the initial appointment. The remaining balance is due at the completion of treatment. We except cash, check, or Visa and Mastercard. Third party financing may also be available with proper credit. In the unfortunate event that payment is not made within the sixty day period and arrangements are not made between this office and the patient, we reserve the right to assign a 10% service charge to your account per month until paid in full.

We strive to provide the best dental care in a caring and gentle environment. As part of our commitment to you, we will do our best to seat you within 10 minutes of your appointment time; however in some cases this is not possible. In order to assure we stay on schedule we ask that if you must cancel your appointment please give a twenty four hour notice. We reserve the right to charge your account a re-sterilization fee of twenty-five dollars if said notice is not made.

AUTHORIZATION

I hereby authorize payment directly to Achord Family Dentistry insurance benefits otherwise payable to me. I authorize the administration of such medications and diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I grant the right to Achord Family Dentistry to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. The information on this page is correct to the best of my knowledge.

In the case of default of payment, I promise to pay any interest on the balance due, together with any collection costs and attorney fees incurred to effect collection of this account.

Responsible party_____ Date_____