

PATIENT INFORMATION

Patient Name _____ Prefer to be addressed as _____

Birthdate _____ Sex _____ Marital Status _____ SSN _____ Drivers Lisc: _____

Home address _____

City/State _____ Zip _____ Home phone _____

Employer _____ Work phone _____ May we call you at work? _____

Email address _____ Cell Phone _____

Preferred method of contact: Home phone _____ Work phone _____ Email _____ Cell phone _____

Student _____ Where? _____ Whom may we thank for this referral? _____

Nearest relative *not living with you* _____ relationship _____ phone # _____

Guarantor (if not same as above) - Please note: we cannot bill a non-custodial parent

Name _____ Relationship _____

Birthdate _____ SSN # _____ Drivers License _____

Billing Address _____

City/State _____ Zip _____ Home phone# _____

Employer _____ Work phone _____ May we call you at work? _____

Other Family Members

Name	Relationship	Employer/School	Work phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Insurance

Primary

Secondary

Insurance Co. Name _____

Billing Address _____

Telephone _____

Group # _____

Policyholder's name _____

Policyholders SS # _____

Relationship to Patient _____

Policyholder's Birthdate _____

Policyholder's Employer _____

I hereby authorize Drs. Miller & McInnis to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____

Policyholder Signature _____ Date _____

FINANCIAL AGREEMENT

Part of a successful dental treatment plan is a clear mutual understanding of the costs involved and the payment terms expected. We ask that you read and sign the financial policy agreement below prior to beginning treatment.

We attempt to make each patient aware of the costs of treatment prior to beginning that treatment and will work with you to estimate what will be owed (deductibles, copayments, and non-covered expenses) after insurance. Please ask if you are at any point unsure of your financial obligation.

PAYMENT IS DUE ON THE DATE OF SERVICE BY CASH, CHECK, OR MAJOR BANKCARD.

Our office also provides extended financing through a third party program especially designed for the needs of dental patients. The financial administrator can review this plan with you and supply you with an application. *Payment by this option needs to be arranged with the administrator prior to scheduling treatment.* I understand that my credit history will be researched if I choose this option.

Balances are considered past due after thirty days, unless insurance claims are still pending. All balances over sixty days are considered past due regardless of insurance status. In special circumstances, the financial administrator may make alternative financial arrangements but this must be arranged prior to treatment. So that the Doctors can concentrate on providing dental care, they do not make financial arrangements. Finance charges (18% APR) are assessed on all account balances over ninety days. These charges can not be waived for reasons of untimely insurance settlements. In the event of default, the patient promises to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

DENTAL INSURANCE

Although the dentist provides the service of filing insurance claims on behalf of the patient, the patient understands that dental insurance is a contract between them and the insurance carrier, and that the dentist is not party to this contract. The patient is responsible for timely payment of all dental fees, regardless of coverage or UCR limits. If insurance has not paid within sixty days, the patient will pay the full balance. Any insurance benefits subsequently allowed will be refunded to the patient or, if desired, held on account towards future treatment.

Estimated insurance benefits are **ESTIMATES** only and does not constitute a guarantee of coverage or relieve the patient of their obligation to satisfy their bill in full. In order for the patient to be fully aware of the benefits which their particular policy provides, they are encouraged to contact their insurance carrier and/or familiarize themselves with the limits and provisions of their policy. Upon request, the office will submit proposed treatment to the insurance carrier for review and pre-estimation. (Most insurance companies will need 4 to 8 weeks to process.)

The patient should bring current insurance information with them to the appointment. Excessive re-billing due to incorrect or incomplete insurance information could result in a re-billing charge.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians) are responsible for full payment, regardless of court child support order. For unaccompanied minors, non-emergency treatment will not be done unless prior approval and financial arrangements have been made.

MISSED APPOINTMENTS

The doctor reserves appointment times exclusively with each patient. We are committed to being here to serve you and ask that you honor your commitment to us as well. The office reserves the right to charge a missed appointment fee for repeated short notice cancellations (less than 48 hours notice) barring sudden illness.

I have read the Financial Policy above. I understand and agree to abide by the terms of this policy.

Signature of Financially Responsible Party

Date