Established Patient – Dental Medical and History Update

Today's Date: _____

Patient Name:_____Date of Birth: _____

Contact Information

Email address:_____

Cell Phone #:_____Home Phone #: _____

Work Phone #:_____

Address:_____

Preferred method of contact (circle one): ☐ Call ☐ Text ☐ Email

Any changes in your Dental Insurance? ◯ Yes ◯ No
If yes, please provide your current Insurance carrier:_____

Any new allergies since your last visit? ◯ Yes ◯ No
If yes, please list:_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any othermember of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ _____

Patients Signature Date

FINANCIAL AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family without any misunderstandings regarding your account.

Our professional services are rendered to patients, thus patients are responsible for charges for treatments rendered. We are unable to provide services on the assumption that the charges will be paid by the insurance company (**AS WE CAN ONLY GIVE ESTIMATES**). The insurance company is responsible to the insured patient. With or without insurance coverage, patients are responsible for full payment of the total bill, unless prior arrangements have been made.

- Payments are due and payable as services are rendered.

- The following methods of payment are accepted: Cash, Checks, Visa, MasterCard, Discover, and Care Credit.

- **Insurance assignment and management:**
    - Patients must provide our office with accurate/current insurance billing information at the time of their appointment, or they are responsible for payment in full.

    - Insurance benefits are a contract between the patient and his/her employer.

    - The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor.

    - Patients are responsible for paying their deductible and their portion at the time of service. Patients are also responsible for paying all charges not covered by their insurance plans including all fees considered above their insurance policy's usual and customary fee schedule.

    - The office will submit a claim up to two times per appointment. Further insurance appeal becomes to patient's responsibility.

    - As an office courtesy, we will accept assignment for the primary insurance coverage. We will also submit to secondary insurance as a courtesy once per date of service. It is the patient's responsibility if a balance remains after 30 days from original submit date to secondary insurance.

- Patients are responsible for balance in full after 60 days even if their insurance company has not paid. Further insurance appeal becomes the patient's responsibility.

- The practice cannot carry balances longer than 90 days. Patients will be informed that their accounts are delinquent before any collection efforts are made. After 3 attempts to contact patient about the balance, then the account be turned over to collection agency or Small Claims and the patient will responsible for additional fees**. *You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 20% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.***

Patient's Initials:_____

- Treatments such as Root Canal Therapy, Crown(s), Denture(s) and other cosmetic procedures such as Whitening require a deposit before treatment is started. The deposit amount must be no less than 1/2 of the total cost. The remaining balance must be paid in full before the final insert and completion of treatment.

- A service charge of $50.00 will be assessed to your account for any checks returned by your financial institution.

- **Broken and Missed Appointments:** We reserve time specifically for you in order to meet all of your dental concerns and needs, so we ask for at least 48 hours' notice for any cancellation and/or rescheduling of an appointment to avoid a $50 charge for our lost time. Exceptions to this rule can be determined only on an individual basis according to circumstances. Work is not an extenuating circumstances you should let you employer know ahead of time that you are unavailable for work at your appointment time.

I have read and accepted the above Financial Agreement. I understand it, and agree to all payment terms regarding my account.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Office Staff Signature Date