PATIENT INFORMATION FORM DATE _____

Patient Name

First _____ MI _____ Last_____ Nickname_____

Address

Street_____ City_____ State_____ Zip_____

Phone

Home_____ Work _____ Cell_____

Email Address_____

What is your preferred method of contact? ☐ Home ☐ Work ☐ Cell ☐ Email

Social Security Number _____ **Date of Birth** _____

Employer _____ **Occupation** _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Phone Number_____

Is the patient a Minor? ☐ Yes ☐No **Student?** ☐ Yes ☐ No School_____

Responsible Party (Required if patient is minor) _____

Relationship to Patient _____ Phone _____

Date of Birth_____ Is this person already a patient with us? ☐ Yes ☐No

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

DENTAL INSURANCE INFORMATION *(Info can be found on your insurance card)*

Name of Insured_____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Dependent

DOB_____ Soc Sec Number _____ Employer _____

Insurance Company Name _____ Phone Number_____

Do you have Secondary Insurance? ☐ Yes ☐ No If Yes, Complete the following:

Name of Insured_____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Dependent

DOB_____ Soc Sec Number _____ Employer_____Insurance

Company Name _____ Phone Number_____

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

PAYMENT: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment. We accept cash, check, all major credit cards and any 'flex-spending' accounts for healthcare. We can also finance your treatment through CareCredit, a 3rd party healthcare credit card. Please let us know if you are interested in applying, we would be happy to assist you.

INSURANCE: Our office provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is **estimated** and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Laguna Village Dental. However, if you are paid by the insurance company instead of us, you then become responsible for the total account balance and payment would be expected immediately. You as a patient are always responsible for any charges that are not covered by your insurance.

MISSED APPOINTMENTS: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. As such, when a patient cancels an appointment it impacts the overall quality of service we are able to provide. **Unless cancelled at least 24 hours in advance, our policy is to charge a fee of $35 and/or to require additional deposits to be paid in advance to reserve any future appointment time.** To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 10 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $35 and/or deposit to reserve another appointment time may be required.

AUTHORIZATION:

- I understand the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. **_____ (Initial)**
- I have read the above and agree to the financial and scheduling terms. **_____ (Initial)**
- I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. **_____ (Initial)**
- I hereby acknowledge that a copy of this practice's Notice of Privacy Practices and the *California Dental Materials Fact Sheet* has been made available to me. I have been given the opportunity to ask any questions I have regarding these notices. **_____ (Initial)**

SIGNATURE _____ DATE_____

PRINT NAME _____