THE DENTAL
ANESTHESIA CENTER

Welcome to Our Practice!

Whom may we thank for referring you? _____

DEPENDENT PATIENT INFO

Date _____

We realize our Dependent Patients have different supported living arrangements. The policy in our office states, **"It is the responsibility of the Parent or Legal Guardian, requesting care to assure this office of complete and prompt payment."**

Patient Last Name _____ First _____ MI _____

Patient Address _____

City _____ ST _____ Zip _____ Sex ☐ M ☐ F Birthdate _____

SS # _____ Medicaid # _____

E-mail _____

Who is accompanying the Dependent Patient today?

Name _____ Organization _____

☐ Parent ☐ Guardian ☐ Case Manager ☐ Support Staff

Legal Guardian Info:

Name _____ Relationship _____

Address _____ City _____ ST _____ Zip _____

Home Ph _____ Work Ph _____ Cell _____

Patient resides in: check one

☐ private home ☐ group home ☐ independent support living ☐ other

BILLING INFO

Payment is due at the time of service. If funds need to be requested from State/Guardian/Caretakers or other source, then the treatment plan and associated costs will be submitted in advance to be secured. The information below is essential in obtaining that info.

Person/Contact for consent forms: _____

Phone # _____ Fax # _____

Person/Contact regarding patient's appointments: _____

Phone # _____ Fax # _____

Person/Contact regarding payment of services: _____

Phone # _____ Fax # _____

Physician Name _____ Ph _____ Fax _____

We accept CASH, CHECK, MC, VISA, DISCOVER and CARECREDIT. As a courtesy to our Patients, we will submit private dental insurance. Co-payment is estimated and due at the time of service. You are financially responsible for your dependents account balance, including any amount your dental insurance does not pay. We do not participate with MEDICAID. See reverse side for private insurance information.

INSURANCE INFO

Primary Policy Holder Name _____ Birthdate _____

SS# _____ ID# _____ Group# _____

Employer _____

Primary Insurance Company _____ Ins Co Ph # _____

Secondary Policy Holder Name _____ Birthdate _____

SS# _____ ID# _____ Group# _____

Employer _____

Secondary Insurance Company _____ Ins Co Ph # _____

AUTHORIZATION AND RELEASE

I authorize the Dentist to release any information, including records of examination, diagnosis, and treatment rendered to me during the period of such dental care to third party payers and/or other health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or behalf of my dependents.

PATIENT AUTHORIZED INSURANCE FORM

THE FOLLOWING APPLIES TO ALL INSURANCE PLANS. IT PROVIDES THE OFFICE WITH AN ORIGINAL SIGNATURE ON FILE, SO SIGNATURE ON CLAIM AT EACH APPOINTMENT IS NOT NECESSARY.

The undersigned, hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned personally signed the particular claim.

Primary _____ _____
Date

Secondary _____ _____
Date

LATE CHARGES

A billing late charge of $10.00 will be assessed each month for accounts over 45 days old. Failure to keep this account current may result in termination of additional services except for dental emergencies in which prepayment will be necessary. In the case of default on payment of this account, Responsible Party agrees to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balances.

Thank You for providing the information necessary to help us serve your dental healthcare needs effectively and efficiently. If you have any questions, please ask.

Emergency Contact _____ PH _____ Relationship _____

X _____