WELCOME

Patient Information **Today's Date: ___ /___ /___**

Patient Name: _____ Preferred Name: _____
First MI Last

Mailing Address: _____
City State Zip

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

Which number would you prefer to be confirmed at: Home ____ Work ____ Cell ____

Birthdate: ____/ ____ /____ Male ___ Female ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

SS #: _____ Drivers License #: _____

(If Married) Spouse Name: _____

Are you a Full Time Student? No____ Yes____ (If Yes) Where: _____

Place of Employment: _____ Address: _____ Occupation: _____

Emergency Contact Name: _____ Phone #: (____)_____ Relationship: _____

Email Address: _____ **REFERRED BY:** _____

Additional Information

Person responsible for account (fill out **ONLY** if patient is under 18 years of age)

Name: _____ Relationship to Patient: _____

Mailing Address: _____
City State Zip

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

Birthdate: ____/ ____ /____ Male___ Female ___

SS #: _____ Drivers License #: _____

Place of Employment: _____ Employment Address: _____

Insurance information

Primary Dental Insurance

Subscriber/Policy Holder Name: _____ Birthdate: ____ /____ /____

Relationship to Patient: _____

Place of Employment: _____ Employment Address: _____

Name of Insurance: _____ SS #: _____ or ID #: _____ Group #: _____

Insurance Mailing Address: _____ Telephone #: (____) _____

As a courtesy we will file any secondary insurance as applicable, however, you are financially responsible for any estimated co-pays based on your primary insurance. You will be notified of any additional payments from your secondary insurance at which time you can request a refund or have the credit applied to your account for future treatment.

Secondary Dental Insurance

Subscriber/Policy Holder Name: _____ Birthdate: ____ /____ /____

Relationship to Patient: _____

Place of Employment: _____ Employment Address: _____

Name of Insurance: _____ SS #: _____ or ID #: _____ Group #: _____

Insurance Mailing Address: _____ Telephone #: (____) _____

INFINITY DENTAL

Welcome to our office! We are honored that you have chosen us as your dental care provider and look forward to working with you. Our dental practice team is committed to providing an excellent dental care experience to you and your family and working with you to achieve that goal. In order to stay focused on providing you with comprehensive dental care we have implemented the following financial protocol. Thank you in advance for your cooperation.

Payment for all treatment is due at the time services are rendered unless other payment arrangements have been made with our administrative staff in advance.

Payment for services may be made by Cash, Check, Visa, MasterCard, Discover, and American Express.

The practice has arranged special dental care financing programs with a few selected third party financial institutions. These special financing programs were arranged to reduce the financial barriers for our patients in receiving optimal dental care. Please ask our administrative staff for further information regarding these special financing options.

Fees quoted for treatment are **estimates** only (based on information gathered by your insurance company) and will remain in effect for 90 days and thereafter are subject to change without notice. In the event clinical conditions warrant a modification in treatment, you will be notified of modifications in treatment and the associated fees prior to proceeding with the modified treatment.

If you fail to show for a scheduled appointment or cancel an appointment with less than 24 hours advanced notice you may be charged a failed/cancellation fee up to $75.

If a check provided by you to the practice in payment for services delivered is returned due to insufficient funds or otherwise, there will be a $35 returned check fee added to the amount due.

If you have dental insurance the practice will work with you to maximize your allowable insurance benefits and will assist in filing your dental claims to your insurance company.

It is understood that the practice will diagnose and recommend treatment based on your dental health and not your insurance coverage. It is further understood that since your dental insurance is a contract between you and your insurance company/ employer, the practice cannot assume responsibility for services not covered under your dental plan.

Unless prior arrangements have been made with our administrative staff all account balances over 90 days old will be subject to further action with submission to a collection agency/attorney. It is understood that any additional legal fees associated with such action will be your responsibility.

Please indicate your understanding and acceptance of these financial guidelines by signing below.

Patient Name (please print): _____ Guardian Name (please print): _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company with-in 60 days of submission.

I hereby authorize doctor or designated staff to take x-rays and any other diagnostic aids deemed appropriate to make a thorough diagnosis of (Patient Name) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

Patient Name (please print): _____ Guardian Name (please print): _____

Patient/Guardian Signature: _____ Relationship to Patient: _____