

Patient Information

PATIENTS NAME _____		DATE _____
_____ Last Name	_____ First Name	
HM # () _____	WK # () _____	CELL # () _____
ADDRESS _____	CITY _____	ST _____ ZIP _____
SSN# _____ - _____ - _____	BIRTHDATE _____	MARITAL STATUS _____ SEX _____
DRIVER LICENSE # _____	ST _____	EXPIRATION DATE _____
EMPLOYER _____	ADDRESS _____	

Responsible Party

PERSON RESPONSIBLE FOR ACCOUNT _____		
RELATIONSHIP TO PATIENT _____	SSN# _____	WK PHONE _____
PHYSICAN/PREVIOUS DENTIST _____	PHONE _____	
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____		
<u>FAMILY INFORMATION</u>		
SPOUSE'S/PARENT NAME _____	WK PHONE _____	
NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU _____	PHONE _____	
IN CASE OF EMERGENCY CONTACT _____	PHONE _____	

Insurance Information

INSURANCE NAME _____	GROUP # _____
POLICY HOLDER'S NAME _____	SSN# _____
POLICY HOLDER'S DATE OF BIRTH _____	EMPLOYER _____
I DIRECT INSURANCE BENEFITS PAYABLE TO THE ATTENDING DENTIST: YES / NO SIGN INITIALS HERE _____	
I WILL PAY TODAY _____ CASH _____ CHECK _____ CHARGE _____	

ACCOUNT OBLIGATIONS

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE ENTIRE COST OF TREATMENT RECEIVED. IF MY FINANCIAL OBLIGATIONS ARE NOT MET AND MY ACCOUNT BECOMES OVER THIRTY DAYS PAST DUE, I WILL BE SUBJECT TO INTERST CHARGES OF 1 ¼ PERCENT PER MONTH AND ANY ADDITIONAL COLLECTION FEES WHICH WILL INCLUDE A MINIMUM OF \$300.00 FOR AGENCY FEES, ATTORNEY FEES, AND COURT CHARGES.

_____ Patients/Guardian's Signature	_____ Date
_____ Witness	_____ Date

OFFICE POLICIES

Please read carefully and sign below.

I, the undersigned, hereby acknowledge informed consent from Creative Dentistry, P.C. for the following policies:

1. PAYMENTS FOR FEES ARE DUE ON SAME DAY OF SERVICE.

2. Some insurance policies require an infection control or office visit fee. Payment for these fees are due on the day of each visit.
3. An examination, set of full mouth x-rays, and a treatment plan will be provided prior to any dental services, except in the case of an emergency, such as bleeding or pain. All x-rays and medical records are property of Creative Dentistry, P.C. You may obtain a copy of your medical record for an additional fee.
4. Financial arrangements and payments for major treatment will be arranged prior to treatment. All prosthodontic procedures and appliances (crowns, bridges, partials, dentures) which require the utilization of professional laboratory services will require a fifty percent (50%) payment prior to laboratory prescription, and the remaining balance will be due upon delivery. All work under \$500 must be paid in full before treatment is begun.

5. Dental insurance is a contract between you employer and a dental insurance company. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company and not your dental office. The goal of most dental insurance policies is to provide only basic care for specific dental services. The services selected are based on the cost of the policy to your employer and the negotiated arrangements with the dental insurance company.

6. **Collections:** It is understood, that you the patient are responsible for the entire cost of treatment received. If your financial obligation is not met, then the following additional charges will be assessed to your account accordingly:

All accounts over 30 days past due will be subject to interest charges of 1 1/2 percent per month (18 percent annually). All accounts over 90 days past due will be sent to a collection agency unless payment arrangements have been made and adhered to. Collection fees will include a minimum of \$300.00, agency fees, attorney fees, and court costs as allowed by the State of TN law.

7. **Returned checks: Fee \$25.00 plus payment of balance.**

8. **Broken appointments:** This office does enforce a broken appointment fee. It is very important that the patient understand that this time is set aside especially for him/her and those appointments should be made only at times when they can definitely be kept. If we are not notified within a 24 hour period, then the appropriate fee will be charged to the patient's account. The broken appointment fees are as follows:

Routine Appointment - one hour or less - \$50.00
Major Appointment - over one hour - \$100.00

9. **X-rays are property of Creative Dentsitry, P.C.**

I have read, asked about anything that was unclear to me, understand and agree to the above policies and terms.

Responsible Party's Signature

Date