****                                                                                                                                             Date

Patients Name                                                                                                                     Preferred Name

Date of Birth                                   Gender :       M          F                      Single      Married

Mailing Address                                                                                                   City                                         State                       Zip

Home Phone Number                                                         Work Phone Number                                                         SS#

E-mail                                                                                                                                     (for appointment confirmation and notifications)

Would you like to receive text confirmations?              Yes          No           Phone Number

Occupation                                                                                                           Employer

If Student, name of School/College                                                                     Part-time     Full-time        City                                       State

Whom may we thank for referring you to our office?

**If person responsible for patient’s account is different from patient or if patient is a minor, please indicate below:**

Name of Responsible Party                                                                                        Relationship to Patient

**PRIMARY INSURANCE INFORMATION**

Policy Holders Name                                                                                        Relationship to Patient

ID/SS#                                                                         Date of Birth                                                    Employer

Insurance Co.                                                                        Phone Number                                                                    Group#

Insurance Address                                                                                              City                                                         State                       Zip

**SECONDARY INSURANCE INFORMATION**

Policy Holders Name                                                                                         Relationship to Patient

ID/SS#                                                                         Date of Birth                                                    Employer

Insurance Co.                                                                        Phone Number                                                                    Group#

Insurance Address                                                                                              City                                                         State                       Zip

**Answers to the following questions are for our records only and will be considered confidential**

1.       Have you or any member of your family been seen by us before? Yes          No

 If yes, which family member (s)?

2.       Date of last physical examination                                                                Physician’s Name

3.       Date of last dental examination                                                                              Date of last dental x-rays

4.       Previous Dentist’s name                                                                City/State                            Phone Number

5.       Are you having pain or discomfort at this time? Yes          No

6.       Do you feel nervous about having dental treatment? Yes          No

7.       Have you ever had a bad experience in a dental office? Yes          No

8.       Have you ever experienced difficulty getting numb for dental treatment? Yes          No

9.       Is there anything you dislike about your smile? Yes          No

10.    Have you ever needed to see a Periodontist? Yes          No

11.    Have you been under the care of a medical doctor during the past two years? Yes          No

12.    Have you ever had any excessive bleeding requiring special treatment? Yes          No

PLEASE COMPLETE BOTH SIDES

**AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS**

I authorize Arbour Family Dental to allow the release my dental and billing information to the following individual(s):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Please provide emergency contact

Name:                                                                                                       Phone number:   (                   )

I certify that I have read and understand the above.  I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.  I will not hold my dentist, or any other member of his/her staff, responsible for the action they take or do not take because of errors or omissions that I have made in the completion of this form and that all questions have been accurately answered.  I understand that providing incorrect information can be dangerous to my health.  I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.  I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.  I understand that that my dental insurance carrier may pay less than the actual bill for services.  I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**FINANCIAL POLICY**

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive proper and optimal treatment needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our office staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard and Discover. For your convenience, we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information.

Our Financial Policy is as follows:

1. Payment for services is due in full at the time of treatment including any co-payments that are estimated.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services, along with unpaid deductibles and co-payment are due at the time of treatment.
5. If the insurance company does not pay after 60 days, we require you to pay the balance due with cash, check, or credit card.
6. Returned checks will be subject to additional fees.
7. All balances over 90 days will be reviewed and turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred.
8. **We reserve the right to charge a fee of $50 per hour for failed appointments or broken appointment when less than 24 hour notice is received.**

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so we may assist you in the management of your account.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentists or any other member of his staff responsible for any action they take or do not take because of error or omissions that I may have made in the completion of this form.

X

 **Signature of Patient/Legal Guardian                                                                               Date**