Dental Associates, Inc.

Patient # | | | | | | | - | | Chart # | | | | | | Date: _____

PATIENT INFORMATION

❑Mr. ❑Mrs.
❑Miss ❑Ms. Name: _____
First Middle Initial Last

Date of Birth: _____ ❑Male ❑Female SS#: _____

How do you wish to be addressed: _____

If child: Parents name: _____

Residence: _____
Street Apt # City State Zip

(If Different) Billing Address _____
Street Apt # City State Zip

Patient/Parent place of employment: _____

Business Address: _____
Street Apt # City State Zip

Home Phone # _____ Business Phone # _____

Cell Phone # _____ e-mail address: _____

If possible, my preferred method(s) for receiving appointment reminders is: [check all that apply]
❑Phone message at home ❑Phone message at work ❑Phone message on my cell phone ❑E-mail

If full time college student, School name: _____ ❑ Letter requested

Spouse/Parent Name: _____ Phone #: _____

Spouse place of employment: _____ Phone #: _____

If patient is a minor, who is responsible for this account: _____

Relation to patient: ❑Mother ❑Father ❑Guardian ❑Other

Address(if different): _____
Street Apt # City State Zip

Other family members in this practice: _____

Whom may we thank for this referral/informing you about our practice:

❑Family member ❑Friend ❑Other Dentist ❑Physician ❑Dental Associates employee ❑Insurance Plan
(name) _____

❑I am a returning patient ❑Walked-In ❑Radio ❑Newspaper ❑Direct Mail ❑Internet
❑Yellow Pages: ❑Quincy book ❑Boston (big) book ❑ South Boston, Dorchester (little) book
❑Other: _____

Is there someone we can talk to regarding your care and/or billing? _____ ❑Care ❑Billing

May we leave messages on your answering machine re:Appointments? ❑Yes ❑No Treatment? ❑Yes ❑No Billing? ❑Yes ❑No

PERSON TO CONTACT IN CASE OF EMERGENCY (Outside of Immediate Family Household)

Name: _____

Address: _____
Street Apt # City State Zip

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

METHOD OF PAYMENT

❑Payment in full at each appointment (❑cash, ❑check, ❑ credit card)

Signature: _____

Form reviewed & entered in computer by:	Date:

INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Subscriber:	Subscriber:
Last First M	Last First M
Address:	Address:
Street	Street
City State Zip	City State Zip
Home #: Work #	Home #: Work #
Cell #: Fax #:	Cell #: Fax #:
Date of Birth:	Date of Birth:
Relation to Patient:	Relation to Patient:
Employer:	Employer:
Dental Ins Co	Dental Ins Co
SS#:	SS#:
Subscriber ID#:	Subscriber ID#:
Policy #:	Policy #:

Medical Insurance Carrier:	Address:
Primary Care Physician:	

AUTHORIZATIONS AND RELEASES

I hereby authorize payment directly to Dental Associates of the group insurance benefits otherwise payable to me.

I hereby authorize Dental Associates to release any information concerning my (my child's) dental/medical histories and other information about my (my child's) dental treatment to third party payors for the purpose of evaluating and administering claims for insurance benefits.

PERSONAL GUARANTEE

-As a courtesy to you, Dental Associates will be happy to submit any bills you incur for dental treatment and services to your insurer for payment. Additionally, our office will make every reasonable attempt to provide estimated costs and secure pre-determination of coverage in accordance with the terms of your applicable insurance plan.

-Neither our submission of bills to your insurer nor the providing of estimated costs shall be considered as agreement on the part of Dental Associates to accept insurance payment as full and complete satisfaction of your obligation to pay for dental services rendered to you and/or other family members.

-You are personally responsible for payment of ALL dental services regardless of insurance coverage. Should you experience issues regarding insurance coverage and/or payment for ANY dental service, it is YOUR responsibility to straighten the matter out with your insurer.

-Be aware that any pre-determination made by your insurer that a particular dental service and/or procedure is covered under your dental plan is not a guarantee of payment for the service or procedure.

-YOU ARE PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL DENTAL SERVICES AND/OR PROCEDURES REGARDLESS OF ANY PRE-APPROVAL GIVEN BY YOUR INSURANCE COMPANY!

-It is your responsibility to be sure that Dental Associates has correct, up-to-date insurance information. If this information is not made available to Dental Associates, no insurance company will be billed.

I certify that the information provided on this page and the dental/medical histories are accurate and complete to the best of my knowledge

SERVICE CHARGE: If I do not pay the entire balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.18% per month (annual percentage rate of 18%) applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

By my signature I acknowledge my understanding of the authorizations and guarantee and, I agree to be personally responsible for payment of any unpaid balance for dental services and/or procedures regardless of whether those services and/or procedures are covered by my dental insurance plan

X Patient or Responsible Party Date

---OFFICE USE ONLY---

Insurance Coverage Confirmation	Date:	Phone #:	Spoke to:	
Type I:	Deductible:	Annual Max:	Missing tooth clause?	Implants?
Type II:	Indiv.		Waiting period?	
Type III:	Family		Perio coverage?	Checked by: