Date _____/_____/_____ CONFIDENTIAL

Personal Information

PATIENT NAME_____ **Birthdate**___/___/___ **SSN** _____-_____-_____
First Middle Last

Address_____

City _____ **State** _____ **Zip** _____ **Home Phone** (_____) _____-_____

CHECK ONE: ___**Minor** ___**Single** ___**Married** ____**Divorced** ____**Widowed** ____**Separated**

PARENT or SPOUSE _____ **Birthdate** ___/___/___ **SSN**_____-_____-_____
First Middle Last

Address_____

City _____ **State** _____ **Zip** _____ **Home Phone** (_____) _____-_____

OTHER PARENT or person responsible for for payment _____ **Birthdate**___/___/___ **SSN**_____-_____-_____
First Middle Last

Address_____**Relationship to patient**_____

City _____ **State** _____ **Zip** _____ **Home Phone** (_____) _____-_____

Employer Information

PATIENT (or Parent) EMPLOYER_____ **Work Phone** (_____) _____-_____

Employer Address _____

Dental Insurance _____ **Group No.** _____

Insurance Address _____

Coverage (check one): ____**Family** ____**Self Only** ____**Self and Dependents** ____**Children Only** ____**Parents Only**

SPOUSE (or Other Parent) EMPLOYER_____ **Work Phone** (_____) _____-_____

Employer Address _____

Dental Insurance _____ **Group No.** _____

Insurance Address _____

Coverage (check one): ____**Family** ____**Self Only** ____**Self and Dependents** ____**Children Only** ____**Parents Only**

Person to contact in an emergency _____ **Phone** (_____) _____-_____

Closest relative not living with you _____ **Phone** (_____) _____-_____

Address_____

Whom may we thank for referring you? _____

PLEASE TURN OVER, READ AND SIGN

PAYMENT AND INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding.

Payment for our services is due at the time the services are rendered unless payment arrangements, made in advance, have been approved. We accept cash, checks, and major credit cards. (There is a twenty dollar fee for returned checks). As an established patient, if you have dental insurance, we can accept insurance assignment of benefits. Such a request must be accompanied by a completed insurance form, and any co-payment due must be paid on the day of treatment. We can arrange financing through a local lender at better than competitive rates.

We will gladly discuss your proposed treatment at any time and answer any questions relating to your dental insurance. If you have dental insurance, you must realize, however, that:

1. Dental insurance is not insurance at all but is actually a form of employee compensation. Employers can choose from extensive or minimal plans depending on their finances and generosity.
2. Your "insurance" contract is a contract between you, your employer and the insurance company. We are not a party to that contract.
3. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R.". U.C.R. is defined as the Usual, Customary and Reasonable fees for a region. Thus our fees are considered usual, customary and reasonable by most companies. However, some companies reimburse based on a "schedule" of fees which bears no relationship to the current standard and cost of care in this area.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Our treatment recommendations are based solely upon your needs and desires.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims and the acceptance of assigned benefits are courtesies that we may extend to you, **all fees are your responsibility** from the date the services are rendered. If we do accept insurance assignment you must be prepared to pay ant balance outstanding after 60 days. Any outstanding balance after sixty days will be subject to an interest charge of 12% per year. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about your treatment or any uncertainty regarding insurance coverage, PLEASE ask us. You are the reason we are here and we are here to help you.

I hereby authorize my current dental insurance provider to release payments of dental benefits to Audubon Family Dentistry for any services provided.

Signature:_____ **Date:**_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents and undergoing dental treatment embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my or my dependents behalf. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1% late charge (12% APR) may be added to my account.

Patient_____ **Date**_____ **Witness**_____

Parent or Responsible Party_____ **Relationship**_____