1111 2nd St.
Rosenberg, Texas 77471
(832) 595-8335

New Patient Information

Patient Name: First_____ MI_____ Last_____ Nickname:_____

Address: Street _____ City_____ State____ Zip_____

Phone: Home _____ Work_____ Mobile_____

E-mail address:_____

By providing your e-mail address you agree to receive (circle one or both)

Appointment Reminders Practice Newsletter

What is your preferred method of contact? (circle each option that works best for you)

Home Phone Work Phone Mobile Phone E-Mail

Social Security Number:_____ **Date of Birth**:_____

Drivers License # _____ **State**_____

Patient Employed By:_____ **Occupation**:_____ _____

Employer's Phone:_____

Address: Street _____ City_____ State_____ Zip_____

Sex : **Male** **Female**

Marital Status: Married Single Divorced Separated Widowed

In case of emergency, who should be notified?_____

Relationship to Patient _____ **Home Phone**_____ **Mobile Phone**_____

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Is the patient a Minor? **Yes** **No** **Full-time Student?** **Yes** **No**

Name of School:_____

Name of Responsible Party: First _____ Last_____

Date of Birth_____ **Relationship to Patient**: **Self** **Spouse** **Parent** **Other**

If patient is a Minor, primary residency: (circle all that apply)

Both Parents Mom Dad Step Parent Shared Custody Guardian

Address: (if different from patient) : Street _____

City_____ State____ Zip_____

Phone: Home_____ Work_____ Mobile_____

Employer (if different from above)_____ **Occupation**_____

Phone:_____

Address: Street_____ City_____ State_____ Zip_____

Insurance Information

Is Patient Insured? YES NO

If <u>NO</u>, who is the responsible party? First_____Last_____

Date of Birth_____**Social Security Number**_____

Is the address for the Responsible Party the same as above? YES NO

If not: Address_____

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If YES, please answer the following:

Name of Insured: First_____Last_____

Date of Birth_____**Social Security #**_____

Insurance Carrier_____**Phone**(located on the back of card)_____

Policy #_____**Group#**_____

Social Sec. # or ID # _____**Employer**_____

Office Policy

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment * *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive

reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

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Scheduling of Appointments: We reserve the Doctor and Hygienist's time on the schedule for each patient procedure, and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $__25.00___ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $_____ or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. (initial)_____

I have read the above and agree to the financial and scheduling terms. (initial)_____

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) (initial)_____

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial)_____

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) _____

Signature_____Date_____