PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI "Called"

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell Phone: _____

Address: _____
Street City State Zip

Person to contact in case of an emergency: Name _____

Phone _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCT.-PRIMARY GUARANTOR

Name _____

Is insured a patient in this practice? ☐ Yes ☐ No ☐ Unsure

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address _____ DOB _____

_____ SS# ___ - ___ - ___

Phone (___) _____

Employed by: _____

Business Address: _____

_____

Insurance Co.: _____

Group# / Policy # _____

Effective Date ☐ Less than 1 year ☐ More than 1 year

PERSON RESPONSIBLE FOR ACCT.-SECONDARY GUARANTOR

Name _____

Is insured a patient in this practice? ☐ Yes ☐ No ☐ Unsure

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address _____ DOB _____

_____ SS# ___ - ___ - ___

Phone (___) _____

Employed by: _____

Business Address: _____

_____

Insurance Co.: _____

Group# / Policy # _____

Effective Date ☐ Less than 1 year ☐ More than 1 year

CONSENT

The undersigned hereby authorizes Dr. Boyd to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Boyd to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____. I also understand the use of anesthetic agents embodies a certain risk. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

X _____ Date _____ Witness _____
SIGNATURE

FINANCIAL POLICY

For your convenience Cash, Visa, MasterCard, Discover and Personal Checks are accepted. Payment is due the day services are rendered.

RETURNED CHECKS: A returned check fee will be charged in the amount of $30.00 for any returned checks written to this office. If a check is returned it may be re-presented to your bank account electronically.

LATE CHARGES: If I do not pay my new balance within 25 days of the monthly billing date, a late charge of 1.75% on the balance not paid will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except where there is prepayment for additional services. In the case of defaults on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Signature X _____

DENTAL INSURANCE GUIDELINES

If you are covered by dental insurance it is important that you are aware of the extent of your coverage. Most insurance programs offer protection for only a portion of the total service you receive. Responsibility for the full charges of your dental service is yours. It will be necessary for you to make proper arrangements to handle both the insured and uninsured portions of your charge. Your policy may base its allowance on a fixed schedule which may or may not coincide with our usual fees.

As a courtesy to our patients, we are happy to assist you by filing your insurance claim. However, if the claim is not paid in 60 days, the balance becomes due and payable by the patient. We urge you to be fully informed of the benefits available to you through your insurance coverage.

I have read and will abide by the office guidelines of Dr. Boyd and further will allow him permission to discuss my conditions with my physician and to request medical information from him.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY TREATMENT AND/OR INSURANCE CLAIM.

X _____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X _____
SIGNED (INSURED PERSON) DATE

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