

WELCOME

Patient Information:

Name: _____
First MI Last

Address: _____
Street City State Zip

Phone #s: () - () - () - () -
Home Work Cell Pager

Email Address: _____

Circle One: Male / Female **Circle One:** Single / Married / Divorced / Widowed

Birthdate: MM / DD / YYYY Age: _____ S.S. #: _____ Driver's License #: _____

Employer/School: _____

Whom may we thank for referring you? _____

Responsible Party Information (If same as above, please check here , otherwise complete the following:)

Name: _____
First MI Last

Address: _____
Street City State Zip

Phone #s: () - () - () - () -
Home Work Cell Pager

Email Address: _____

Circle One: Male / Female **Circle One:** Single / Married / Divorced / Widowed

Birthdate: MM / DD / YYYY Age: _____ S.S. #: _____ Driver's License #: _____

Employer/School: _____

Insured Party Information (If yourself, please check here , if responsible party check here , otherwise complete the following:)

Name: _____
First MI Last

Address: _____
Street City State Zip

Phone #s: () - () - () - () -
Home Work Cell Pager

Email Address: _____

Circle One: Male / Female **Circle One:** Single / Married / Divorced / Widowed

Birthdate: MM / DD / YYYY Age: _____ S.S. #: _____ Driver's License #: _____

Employer/School: _____

Emergency Contact Information (Not residing in your household) _____ Relationship

Name: _____
First MI Last

Phone #s: () - () - () - () -
Home Work Cell Pager

Doctor's Notes: _____

Dental Insurance

Your insurance policy is a contract between you and your insurance provider. Our office files insurance claims as a courtesy to our patients. We *estimate* what your insurance *will* pay to the best of our ability. However, in the event that your insurance does not pay the estimated amount (or makes no payment at all) any balance remaining on your account is your responsibility. We are not responsible for any denial of claims if correct insurance information is not provided. It is also your responsibility to inform us of any changes to your insurance coverage. Please provide proof of insurance coverage to the receptionist. _____

Initials

Authorization and Release*

 (Required if our office is to file your insurance.)

I authorize the dentist to release any information regarding the diagnosis and record(s) of any treatment or examination rendered to my child or myself during the period of such dental care to third-party payors and/or other health practitioners. I request and authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Signature of patient or guardian if minor

Financial Policy

Payment is expected in full at each appointment unless other arrangements are made.

Payment Methods:

For your convenience we offer the following methods of payment:

Cash or Personal check

Credit Cards: Visa, MasterCard, Discover, American Express, Citi Health Card, and Healthcare Creditline.

Late Charges:

If I do not pay the entire balance within 60 days, a finance charge of 1.8% on the unpaid balance will be assessed each month. I realize that failure to keep this account current may result in this office being unable to provide additional dental services other than dental emergency treatment for which prepayment arrangements have been made. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. _____

Initials

Late Cancellation Fees:

An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and you will be present for that appointment. It is customary and required that we receive a minimum of 24 hours notice of any change in your scheduled appointment(s). Cancellation messages left on the voice mail Friday through Sunday are not considered adequate notice for Monday appointments. A fee of \$50 will be assessed for missed or late-cancelled hygiene appointments. A fee of \$100 will be assessed for missed or late-cancelled doctor's appointments. Illness, emergency situations, and other extenuating circumstances will be taken into consideration. _____

Initials

Office Information

Phone Number: (719) 527-9098

Office hours: Monday - Thursday 8:00 a.m. - 1:00 p.m. and 2:00 p.m. - 6:00 p.m.

Our phones are answered 24 hours a day, 7 days a week, either by our staff or our answering service. Dr. David and/or Branon Johnson, or an on-call doctor can be contacted 24 hours a day for emergency needs.

I certify that the information I have provided is correct to the best of my knowledge.

Signature of patient or guardian if minor

Date