PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767/27000 COLWELL 1.800.637.1140

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

To our uninsured patients:

Payment in full is expected at the time of service unless written financial arrangements have been made with this office.

To our insured patients:

Each employer's plan is slightly different in its covered services. Your dental insurance plan is designed to share in the cost of your dental treatment and most often will not cover the entire cost. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround, if capabilities are available.
3. Re-filing your insurance claim a second time within 30 days.
4. Helping you to receive the maximum benefits available under your policy.
5. Allowing payment with all major credit cards (Visa, Mastercard, Discover and American Express)

Our expectations of you include:

1. Payment of fees not covered by your insurance plan at the time service is rendered.
2. Providing our office with accurate insurance and employment information.
3. Understanding that your insurance policy belongs to you and that we have no leverage to obtain payment from your insurance carrier.
4. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
5. Taking responsibility for payment of all fees if the insurance company does not pay our office after 30 days.

Dental Insurance Authorization and Release of Information

I hereby authorize payment of my insurance benefits to the office of Pediatric Dentistry North. I understand that I am responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____
Insured or Responsible Party

_____
Date

METHOD OF PAYMENT (please check)

Cash___ Check___Credit Card___Insurance____Medicaid___

CONSENT
If the patient is a minor it is necessary that a signed permission be obtained from a parent or legal guardian before any dental services can be performed. I grant David L. Morgan, D.D.S and D. Scott Morgan, D.D.S., and employees of Pediatric Dentistry North to provide dental treatment and I will be responsible for the cost of the dental care. I understand that I am financially responsible for all treatment fees, including any amounts not paid by my insurance company within 30 days following treatment. I understand that there is a 1 ½ % monthly finance charge applied to account balances that are more than 60 days past due. Should it be necessary to refer my account to an attorney or agency for collection, I agree to pay all attorney, court and collection fees.

_____ _____
Signature of Patient/Parent/Guardian Date