

I have read the Notice of Privacy Practices at Dental Arts of Great Valley and grant the staff permission to share my medical information with agents and agencies involved in my care.

Signature of patient, parent, or guardian:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Referral Information**

How did you hear about us?

□ Insurance □ Another patient, friend □ Another patient, family □ Drive-By □ZocDoc

□ Internet Search □ Doctor/Clinic □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person who referred you to our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Responsible Party Information**

The following is for: □ self □ the patient’s spouse □ the person responsible for payment

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Male □ Female □ Married □ Single □ Parent/Guardian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

best way to contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Apartment Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State Zip Code

**Employment Information**

The following is for: □ the patient □ the person responsible for payment

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip Code

**Insurance Information**

Primary

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Subscriber the patient? □ Yes □ No

Subscriber’s Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip Code

Patient’s Relation to Policy Holder: □ Self □ Spouse □ Child □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Subscriber the patient? □ Yes □ No

Subscriber’s Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip Code



***If you need to cancel or reschedule your appointment, we kindly ask that you give us a 24 hour notice so we have time to schedule another patient.***

***A $50 fee is charged for all missed appointments if sufficient notice is not given.***

***Thank you!***

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With my signature I acknowledge that if I need to cancel or reschedule my appointment, I have 24 hours to give notice. If my cancellation falls within 24 hours of my set appointment time, I could be charged a $50 fee for each appointment cancelled or missed.

Signature

Print name



Financial Policy

My signature below shall serve as my authorization to assign any dental benefits paid by any third-party insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered.

 I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, coordination of benefit rules and information received from me. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility.

 Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances.

 As a courtesy, this office will prepare insurance forms and assist in making collections from insurance companies. However, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party paper fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account.

 If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in advance.

 Treatment plan estimate is an estimate of the potential costs that can be incurred during treatment. This is a dynamic number that can change if the treatment itself changes during delivery. Unforeseen clinical issues, esthetic concerns, or functional considerations may come up that will limit our original treatment plan and we may need to alter it.

 All changes will be discussed with the patients upfront and financial repercussions addressed as needed.

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_