CompleteDentalHealth

YOUR SMILE IS OUR REWARD

619.295.2202 • www.completedentalhealth.com

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PATIENT INFORMATION

Name (Mr., Mrs., Ms. Dr.) ______________________________
Last First Middle

Residence/Address ______________ City ______________ Zip ______________

Business/Address ______________ City ______________ Zip ______________

Home Phone # ______________ Business Phone # ______________

Cell Phone # ______________ E-mail Address ______________

Date of Birth ____/____/____ Social Security # ______________

If patient is a minor, Name of mother and father ______________

Place of Employment ______________

Occupation/Former Occupation ______________

SPOUSE INFORMATION

Name ______________ Date of Birth ____/____/____

Employer ______________ Occupation ______________

IN CASE OF EMERGENCY

Person To Contact ______________ Phone # ______________

Friend/Relative Not Living with Patient ______________ Phone # ______________

REFERRAL SOURCE

Whom may we thank for referring you? ______________

If not referred, how did you hear about us? ______________

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible For Payment of Account ______________ Relationship ______________

Mailing Address ______________ City ______________ State ______________

Date of Birth ____/____/____ Phone # ______________ Zip ______________

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan ______________

Policy or Group # ______________ Subscribers Name (if different) ______________ SSN of Subscriber ______________

Name of Secondary Dental Insurance Plan ______________

Policy or Group # ______________ Subscribers Name (if different) ______________ SSN of Subscriber ______________

There will be a charge for broken appointments without 24 hours notice. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services.

Signature ______________ Date ____/____/____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-11/2% finance charge (18% APR) may be added to my account.

Patient ______________________ Date ___/___/___ Witness ______________________

Parent or Responsible Party ______________________ Relationship to Patient ______________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records)including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

Name of Patient ______________________ Date ___/___/___

Signature of Patient, Parent or Guardian ______________________

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of Complete Dental Health to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Name of Patient ______________________ Date ___/___/___

Signature of Patient, Parent or Guardian ______________________

I understand that Complete Dental Health will make every effort possible to assist me with my insurance coverage. CDH allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, CDH will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or any other balance not paid by my insurance company. CDH requires my estimated portion at the time treatment is rendered.

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 24 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 24 hours notice, I will either be required to pay a fee of $50 per scheduled hour before a new appointment time will be made for me, or be put on a short call list.

Name of Patient ______________________ Date ___/___/___

Signature of Patient, Parent or Guardian ______________________