

Welcome

PATIENT INFORMATION

Patient Full Name _____

Birth date _____ SS# _____

FINANCIALLY RESPONSIBLE PERSON(S)

Full Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

SS# _____ Birth _____

Phone (h) _____ (m) _____

Email Address _____

Employer _____ Ph. (w) _____

Spouse/Guardian Name _____

SS# _____ Birth _____

Employer _____ Ph. (w) _____

WHOM MAY WE THANK FOR REFERRING YOU?

Friend, Relative, Physician, Dentist, Internet,

Yellow Pages, Newspaper, Other Media, Fair

Other _____

Their name _____

We want to get to know you? Tell us a little bit about yourself: family, job, favorite foods, favorite movies, favorite music, favorite things to do:

YOUR DENTAL HISTORY

Who was your previous dentist?

Name _____

City _____ State _____

Phone _____

Why did you leave your previous dentist?

CANCELLATION FEE POLICY

Please be advised there will be a cancellation fee charged for missed appointments or appointments rescheduled within **24 hours** of the original appointment time. The fee will be a minimum of \$25 or may be assessed at 20% of the scheduled procedure rate.

I have been advised of Endless Smiles Dental's cancellation fee policy.

Patient Signature _____

TELL US ABOUT YOUR SMILE

If you could change your smile, would you:

(Please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings w/ tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

Do you like your smile? Yes No

On a scale of 1 to 10, with 10 being the highest rating:

(Please circle the number that best applies to you)

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

DISCLAIMER

I understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize release of all identifiable information concerning my account, including charges billed, payments made, and interest charges assessed to Endless Smiles Dental and any agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to be made directly to Endless Smiles Dental.

Signature _____

Today's Date _____

For Dental Insured Patients

initial

Insurance Coverage:

Dental Insurance can be confusing and can not be compared to Health Insurance. Our goal is to help maximize your dental benefits, but it is your responsibility to know your insurance. Please remember that the benefits available under the terms of your dental contract have been **determined by your employer** and your insurance carrier. We care for you **based on proper dental standards, not on an insurance company's benefit package**. This dental office treats patients with hundreds of different insurance plans and benefit structures. **We cannot accurately predict before or during treatment what will be paid (if any) on your claims**, therefore expect a statement after treatment.

initial

Why would I get a statement after treatment?

Your ESTIMATED co-pay is due in full the day of treatment, and then we will bill your insurance. Once your claim has been processed and returned to our office, any remaining balance due to denied or partial coverage will be billed to you and expected to be paid promptly by you. We will credit all collections received to the designated account.

PRIMARY DENTAL INSURANCE:

Name of subscriber _____
Relation of subscriber to patient _____
Employer _____
Name of insurance co. _____
Subscriber Birth date _____ SS# _____

SECONDARY INSURANCE:

Name of subscriber _____
Relation of subscriber to patient _____
Employer _____
Name of insurance co. _____
Subscriber Birth date _____ SS# _____

Payment Arrangements for all Patients

Endless Smiles Dental strives to offer convenient payment options while at the same time maintaining high standard of comprehensive dental care that you deserve. Our goal is to take good care of you and your family and to help you afford your dental choices. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, **financial responsibility on the part of each patient must be determined before treatment.**

At the onset of treatment, we will provide you with an **ESTIMATE** of the total fees expected. Please understand this will only be an estimate. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

Please take a moment to review the financial plans and **INITIAL** in the box, (do not check), your preferred form of payment.

initial

Plan A: Prepayment Courtesy

We offer a 5% bookkeeping courtesy for all treatment that is paid in full prior to the day of treatment by check, cash, credit or debit card.

initial

Plan B: Payment as services are rendered

You may use cash, check, credit or debit card to make payment at the time of service. We gladly accept MasterCard, Visa, and Discover Card.

initial

Plan C: Monthly Payment Plans

If you want to make monthly payments, we offer short and long-term financing through Care Credit. ****By checking this box, you will authorize one of our team members to obtain your credit report and assist you with the application process.****



In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the dentist, I agree to pay the reasonable value of services rendered to Endless Smiles Dental at the time services are rendered or within five (5) days of rendering said services. I understand that I am financially responsible for all charges whether or not paid by an insurance company. I understand that Endless Smiles Dental cannot render services on the assumption that charges will be paid in full by an insurance company. I agree that if payment cannot be made at time of service, treatment may be denied and I am responsible for any damage incurred.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

I am aware in the event that payment in full for charges incurred is not made within **60 days** of my treatment; I agree to pay all costs of collection including a **40% collection fee**, attorney costs, and court costs.

I understand that there will be a \$25 charge on all returned checks. I understand after one check is returned, the only method of payment this office will accept is cash or credit.

I grant my permission for Endless Smiles Dental to contact me at home or at my place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering machine or with a family member.

This agreement supersedes all prior arrangements signed, including any and all mediation/arbitration agreements. I acknowledge that any prior agreements related to financial arrangements or quality of care are null and void. I hereby agree to abide by the condition outlined herein.

Patient Signature _____

Today's Date _____

