PATIENT INFORMATION FORM

Patient name: First:_____ MI:_____ Last:_____ Nickname:_____

Employer: _____ Occupation: _____

On a scale of 1-10, how nervous are you about coming to the dentist (1 being not at all nervous): _____

Previous dentist: _____ How long since your last dental visit: _____

Pharmacy: _____ Phone number: _____

DENTAL BENEFIT PLAN INFORMATION

Primary dental plan name: _____Phone number: _____

Address: Street:_____ City:_____ State:____ Zip: _____

Name of insured: _____ Date of birth: _____ ID #: _____

Group #: _____ Relationship to insured: _____

Secondary dental plan name: _____ Phone number: _____

Address: Street:_____ City:_____ State:____ Zip: _____

Name of insured: _____ Date of birth: _____ ID #: _____

Group #: _____ Relationship to insured: _____

MEDICAL PLAN INFORMATION

Plan name: _____ Phone number: _____

Address: Street:_____ City:_____ State:____ Zip: _____

Name of insured: _____ Date of birth: _____ ID #: _____

Group #: _____ Relationship to insured: _____

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) _____ ☐ Postcard

☐ Website ☐ Other (please specify) _____

PATIENT RESPONSIBILITIES:

We are committed to providing you with the best possible care & helping you to achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

PAYMENT:

Payment is due at the time that services are rendered. Financial arrangements are discussed during the initial visit. We accept the following forms of payment: Visa, Mastercard, Discover, Cash, Check, & Carecredit Financing Credit Card.

DENTAL BENEFIT PLANS:

Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We do our best to give you an accurate estimate; however, it is not a guarantee of payment. The amount not covered by the dental benefit is the responsibility of the patient.

SCHEDULING OF APPOINTMENTS:

We reserve the dentist's or hygienist's time for each patient procedure and we strive to be punctual. When we receive last minute cancellations or no-shows, it does not allow us the opportunity to offer that reserved time to another patient. For this reason, we require 48 hours of notice to cancel or reschedule an appointment. With less than 48 hours of notice, a fee of $50 will be charged. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient arrives more than fifteen minutes late for their scheduled appointment.

AUTHORIZATIONS:

The information I have been given today is correct to the best of my knowledge. I authorize Scituate Family Dental to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (Initial)

I have read the above and agree to the financial and scheduling terms: _____ (Initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this dentist otherwise payable to me. _____(Initial)

I hereby acknowledge that a copy of this practice's notice of privacy practices has been made available to me. I have been given the opportunity to ask any questions that I may have regarding this notice. _____ (Initial)

Signature: _____ Date: _____