

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____
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 _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

It's About Expectations...

We very much appreciate and value you as a patient in our practice. So that we may continue to have an excellent, mutually beneficial relationship, we would like to take this opportunity to reiterate our office expectations.

As a patient of our practice, you can expect us to:

- ◆ Greet you in a friendly, professional manner.
- ◆ Seat you as soon after your arrival as possible.
- ◆ Outline the cost associated with any treatment before beginning.
- ◆ Strive to perform painless dentistry.
- ◆ Provide the most advanced dental procedures and materials.
- ◆ Explain the treatment being performed.
- ◆ Maintain and clean office.
- ◆ Sterilize all instruments and disinfect all treatment rooms.
- ◆ Do everything possible to make you feel welcome and comfortable.
- ◆ Treat you with the utmost professionalism and personal attention.
- ◆ Assist you in processing your insurance claims not to exceed eight weeks.
- ◆ Remind you of your scheduled appointments a day in advance.
- ◆ Treat any friends and family you refer to us with the same friendly, personal attention.

As a patient of our practice, we expect you to:

- ◆ Keep your scheduled appointments. We do require a two business day notice for any appointment changes to avoid a \$75 cancellation fee.
- ◆ Arrive on time for your appointments.
- ◆ If you have insurance, pay your estimated insurance portion at the time services are rendered. There is a \$40.00 returned check fee.
- ◆ If you do not have insurance, pay for your services at the time they are rendered.
- ◆ Provide us with current and accurate insurance information.
- ◆ Keep us updated regarding changes in your personal information, such as address and telephone numbers.
- ◆ Notify us of changes of your general health status, including any special needs that you may have.
- ◆ Brush and floss daily as recommended by our staff.
- ◆ See us regularly for exams and cleanings as recommended by our doctors and staff.
- ◆ Feel comfortable referring your friends and family members to our office.

Signed _____
Patient

Signed _____
Cordera Family Dentistry

Date _____

Date _____

**Cordera Family Dentistry
Hans Egbert D.D.S.
Policy Form**

Office Financial Policies

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service.**

If your insurance has not paid within 60 days from the date from the date of service, we will look to your for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution

Signature

Insurance Regulations

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health care information to carry out payment activities in connection with claims submitted from this office.

Signature

Assignment of Benefits

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Cordera Family Dentistry.

Signature

Name of Practice: CORDERA FAMILY DENTISTRY

Name of Patient (please print)

Date of Birth

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received [Cordera Family Dentistry]’s Notice of Privacy Practices.

Signature of patient or patient representative

Date

**Documentation of Good Faith Efforts
To obtain patient’s acknowledgment that they received provider’s
Notice of Privacy Practices**

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity’s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form

Date