Revised 2018

CURRENT DENTAL PATIENT INFORMATION

Please fill out both pages of this form completely – Please print clearly

Date:_____/_____/_____

Last Name:_____ **First Name**:_____ **Middle**_____

Birth date_____/_____/_____ **Sex:** M___ F___ **Social Security #**:_____ - _____ - _____

Mailing Address:_____ **City**_____ **State:**_____ **Zip**:_____

Home # (_____)_____ **Cell#** (_____)_____ **Work #**(_____)_____

Email_____ **YES/NO** I will receive text messages and emails

Employer: _____ **Phone #**:(_____)_____

How did you hear about us?: _____

Primary Insurance Information

It is the patient's responsibility to provide complete and accurate information for insurance billing. If your insurance card did not get photocopied today, then you need to complete the section below.

Primary
Insurance Co._____ Group #_____ I.D./Claim #_____

Primary Member on Insurance: Last name:_____ First name:_____ Initial:_____

Date of Birth:____/____/_____ Sex: M____ F____ Social Security # _____ - _____ - _____

Home Address:_____ City:_____ State:____ Zip:_____
(If different from above)
Home # (_____)_____ Work # (_____)_____ Employer:_____

Relationship to patient: Self:____ Spouse:____ Parent:____ Guardian:____

❖ *Do you have a Secondary Insurance you would like us to bill? Yes ___ No ___ if yes please complete the next section*

Secondary Insurance Information

Insurance Co._____ Group # _____ I.D. #_____

Primary Member on Insurance: Last name:_____ First name: _____ Initial:____

Birth date: ____/____/_____ Sex: M___ F___ Social Security # _____ - _____ - _____

Home Address:_____ City:_____ State:____ Zip: _____
(If different from above)
Home # (_____)_____ Work # (_____)_____ Employer: _____

Relationship to patient: Self:____ Spouse:____ Parent:____ Guardian:____

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Emergency Contact - (Specify someone not living with you)

Name: _____ Relationship to Patient: _____

Home # (____)_____ Cell# (____)_____ Work (____)_____

❖ **RELEASE OF INFORMATION**

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Current Dental may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of Current Dental charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers.

√ **Initial:** _____

❖ **ASSIGNMENT OF INSURANCE BENEFITS AND RESPONSIBILITY FOR PAYMENT**

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Current Dental of any insurance benefits, otherwise payable to or on behalf of the undersigned for these outpatient services including emergency services if rendered, at a rate not to exceed Current Dental regular charges. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

√ **Initial:** _____

❖ **CONSENT FOR SERVICES**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

I acknowledge that I am responsible for payment of all services rendered to me by CURRENT DENTAL. I understand that as a courtesy, this office will file the necessary forms with my insurance(s). However, there is no guarantee of coverage because my insurance policy is an agreement between the insurance company and the insured. I am ultimately responsible for payment in full of the account.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

In addition to the fees charged for services rendered, I will be charged a $25.00 NSF handling fee and a $50.00 fee for no/shows or last minute cancellations. In addition, if my family must move on to another dentist, I will be provided a copy of our appropriate dental records for a nominal charge when applicable. I understand that Current Dental has a minimum of 3 business days to process any records requests.

I understand that when appropriate, credit bureau reports may be obtained..

I have read the above conditions of treatment and payment. I agree to these conditions. √ **Initial:** _____

My signature acknowledges my understanding and consent to all of the above information and that the details provided are accurate.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Print name if signed on behalf of the patient **Relationship**