Date: _____

Patient Information

This information is necessary for our files and will be considered **CONFIDENTIAL**.

PATIENT INFORMATION

Last Name _____ M.I.____ First Name _____Preferred Name _____

Select one: Minor/ Single/ Married/ Divorced/ Separated/ Widowed

Preferred Language: English Only/Bilingual

Birth Date _____ Age _____ Gender: Male/Female

Social Security #_____ Driver's License #_____ State_____

Phone#_____ Email_____

Address_____ City_____ State_____ Zip_____

Patient's Employer_____ Occupation_____

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired Student Status: [ ] Full Time [ ] Part Time

Who should we notify in case of emergency?_____ Phone _____

Who referred you to our office?_____

Office ads seen: [ ] flyer [ ] coupon referral [ ] mailer ad [ ] ad in bulletin [ ] other:_____

RESPONSIBLE PARTY

Person responsible for account_____ Relationship _____

Social Security #_____ Birth Date _____ Email_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Work #_____

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured _____ Relationship to Insured: [ ]self [ ]spouse [ ]child [ ]other

Insured Soc. Sec.#:_____ Insured Birth Date: _____

Name of Dental Insurance _____Group No. _____

Insurance ID No. _____ Insurance Phone #_____

Secondary Insurance Information

Name of Insured _____ Relationship to Insured: [ ]self [ ]spouse [ ]child [ ]other

Insured Soc. Sec.#:_____ Insured Birth Date: _____

Name of Dental Insurance _____Group No. _____

Insurance ID No. _____Insurance Phone#_____

FINANCIAL AGREEMENT

Payment is due at the time of service unless prior arrangements have been made.

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our front desk for an approximate cost prior to treatment. For your convenience, we accept cash, check, VISA, MasterCard, Discover, American Express, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE

If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill

regardless what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption your charges will be paid by your insurance company.

In consideration for the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency, a collection fee of 40% of the account balance will be added and must be paid by the patient. I grant my permission to you to telephone me at home to discuss matters related to this form.

There is a $25.00 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or money order only.

I have read and understand Mission Family Dental's Financial Agreement

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Patient /Guardian Signature Date

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all our patients. When an Appointment is scheduled, that time has been set aside especially for you and when it is missed, that time cannot be used to treat another patient

For your convince we call the day prior to confirm and we also use a company called **Lighthouse 360** to remind you of scheduled appointments through text and/or email.

Our policy is as follows:

We require that you give our office **24 hours**' notice in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$125** will be charged to you; this fee cannot be billed to your dental insurance company and will be your direct responsibility.

Additionally, if a patient is more than **15 minutes** late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$125** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms.

_____

Signature of Patient Date