Welcome

ABC DENTAL

Please fill out all sections

Today's Date_____

Personal Information

Name (first)_____ (middle)_____ (last)_____

Address _____

City _____ State _____Zip_____

Social Security Number _____– ____ – _____Birthdate _____Driver's Lic # _____

☐Male ☐Female ☐Minor ☐Married ☐Divorced ☐Widowed

Employer _____ Occupation_____

Referred by: ☐Google /Yelp ☐Insurance Company ☐ www.dranagrace.com ☐Dental Specialist

☐Friend, Relative, Co-worker Please Name _____

Responsible Party **(Who is responsible for the account?)** ☐Same As Above

Name_____

Address _____

City _____ State _____Zip_____

Relationship to patient _____Birthdate _____

Social Security Number _____ –_____– _____

Employer _____ Occupation_____

Work Phone_____ Home Phone_____

Telephone

Home Phone _____Work Phone_____

Cellular Phone_____ E-Mail Address _____

Where do you prefer to receive calls? ☐Home ☐Work ☐Cellular

When is the best time to reach you? Time_____ Days_____

Emergency Contact **In the event of an emergency, who should we contact?**

Name_____ Relationship_____ Work #_____ Home #_____

Financial Policy

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

☐ Cash

☐ Personal Check Checking Account #_____ Bank _____

☐ Master Card Card # _____ Exp. Date _____

☐ Visa Card #_____ Exp. Date _____

☐ Discover Card #_____ Exp. Date _____

☐ American Express Card #_____ Exp. Date _____

☐ Care Credit Dental Outside Financing

☐ Flex Spending Account or Medical Savings Account

1. Our Office requires payment in full for treatment fees and/or insurance co-payment at the time of the procedure. Please make financial arrangements prior to procedures.
2. A charge of $30 will be charged for any returned NSF checks.
3. We reserve the right to change for broken or cancelled appointments without 48 hours notice.

ABC DENTAL

Dental Insurance Information

Primary Insurance

Name of Insurance Company _____

Name of Insured _____ Insured's Birth Date _____

Social Security # _____ Date Employed _____

Name of Employer _____

Address of Employer _____ City _____ State _____ Zip _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance

Name of Insurance Company _____

Name of Insured _____ Insured's Birth Date _____

Social Security # _____ Date Employed _____

Name of Employer _____

Address of Employer _____ City _____ State _____ Zip _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Authorization and Release

I authorize the office of Dr Ana Grace Santos, DDS. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners.

If I have dental insurance, I authorize and request my insurance company to pay directly to Dr Ana Grace Santos, DDS insurance benefits otherwise payable to me.

As courtesy, we will initiate a claim to your insurance company on your behalf and will be happy to assist you. However, please keep in mind that insurance is a method for patients to be reimbursed for fees they have paid for dental services. Your insurance coverage is a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT OUR OFFICE. Insurance companies reimburse at various amounts, based on each subscriber's individual contract. HAVING INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT OR YOUR CHARGES, AND YOU ARE RESPONSIBLE FOR FULL PAYMENT OF YOUR ACCOUNT WITHIN 45 DAYS OF SERVICE, REGARDLESS OF THE STATUS OF ANY INSURANCE CLAIMS.

I have read and understand the above policy. I agree to be ultimately responsible for payment of all services rendered on my behalf or my dependents.

X _____ **X** _____

Signature of patient or parent if minor **Date**