Fox's Spokane Denture Clinic, Inc.®

***NEW PATIENT* DATE:**_____/_____/_____

Patient Information

How did you hear about us? Google - Yellow Pages - Facebook - Other ___

NAME (first – last - middle Initial):_____,_____, _____

D.O.B:___/_____/_____ **SEX:** M / F

PRIMARY PH#( )_____-_____**SECONDARY #**( )_____-_____**EMAIL:**_____@_____

ADDRESS: _____ **CITY:** _____ **STATE:**_____ZIP: _____

Emergency Contact Name:_____**Phone #**( )_____-_____**Relation:** _____

Health Information

Dental Insurance Company: _____ **Are you the policy holder?** YES / NO
(If not please fill out the info below)

Policy Holder:_____,_____**Policy Holder Date of Birth:**_____/_____/_____
Last Name *First Name*

Policy ID #_____**Group #** _____
(**Use SSN# if unsure)**

Herpes____
HIV/AIDS ____
Thrush____
Hepatitis ___
Irreg. Blood Pressure __
Anemia ___
Asthma____
Cancer____
Diabetes____
Epilepsy ___

Head / Neck ___
Injury ___
Heart Condition ___
Pacemaker____
Rheumatic Fever __
_____
Sinus troubles ____
Stroke____
Tuberculosis____
Ulcers ___
Prolonged Bleeding __

Physician, Dr._____**Ph#**( )_____- _____
Please list any medication you are currently taking:
Med:_____ **For:** _____
Med:_____ **For:** _____
Med:_____ **For:** _____
Med:_____ **For:** _____

Do you have any other noteworthy health conditions?

_____

Other STDs/STIs
➢ If yes, _____

Women Only:
Are you Pregnant? __

Your Dental Provider:_____**Ph#**( )_____-_____**Dr.** _____

Is all your dental work complete, including extractions and restorative treatment? YES / NO, _____

Financial Policy

When treatment is decided, policy requires at minimum either: (A) A down payment of half the amount or (B) The approval of a payment plan. At the end of service, the remaining balance is due before services are delivered unless a payment plan is already in agreement. This applies for all services.

Refunds are not guaranteed.

Service Agreement

Once services begin I am responsible for the entirety of the balance. I recognize the 20% non-refundable service fee that applies if I decide to terminate service or change my mind. This applies during the construction of my prosthetics or after delivery of the same.

Insurance Policy

Before treatment begins, we do our best to ensure that insurance benefits are used to the best of our capability. We also attempt to get estimates for policy. However, instances do occur when the insurance company denies a claim for a variety of reasons – some outside of our control. If your insurance refuses to pay for treatment rendered at our office, you will be responsible for the remaining balance.

By signing below,
I agree to the policies of Fox's Spokane Denture Clinic

Print_____

Signature_____