Fox's Spokane Denture Clinic, Inc.

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

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

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

D.O.B: / / **SEX *(circle)* :** Male / Female

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

Health Information

Note: Failure to provide correct information will cause delays with insurance responses and payment

***if Delta Dental, please indicate state (ie: Washington, Idaho, etc.)**

Dental Insurance Company: _____ **Are you the policy holder? *(circle)*** : YES / NO

Policy Holder Name: _____**Policy Holder Date of Birth:** _____/_____/_____

Policy ID # _____ **Group #** _____

(Use SSN# if unsure)

Name of Your Dentist/Oral Surgeon: _____**Ph#**( ) _____ - _____

***Is all your dental work complete, including extractions and restorative treatment*? *(circle)* YES / NO**

Please mark ✓ to indicate 'Yes' as your response to the following:

Herpes ____
HIV/AIDS ____
Thrush ____
Hepatitis ____
Irreg. Blood Pressure ____

Anemia ____
Asthma ____
Cancer ____
Diabetes ____
Epilepsy ____
Other STDs/STIs _____
➢ If yes, _____

Head / Neck ____
Injury ____
Heart Condition ____
Pacemaker ____
Rheumatic Fever ____
Sinus troubles ____
Stroke ____

Resident at a skilled nursing/alternative living facility? (circle) YES / NO

Do you smoke cigarettes/e-cigarettes?
(circle) Yes / NO

Check here if none of the above conditions apply to you

Physician, Dr._____
Ph# (**)** _____ - _____

Do you have any other noteworthy health conditions?
_____

Please list current medications here:
Med: _____ For: _____
Med: _____ For: _____
Med: _____ For: _____

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 25% (30% if implant-related) 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.

Print_____

Signature_____