

Welcome

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 Single Married Divorced Widowed

Employer _____ Occupation _____

Referred by: Yellow Pages Insurance company Christian Blue Pages Dental Specialist
 Friend, Relative, Co-worker Please Name _____

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

Name _____

Home Address _____

City _____ State _____ Zip _____

Relationship to patient _____ Birthdate _____

Social Security Number ____ - ____ - ____

Employer _____ Occupation _____

Work Phone _____ Home Phone _____

Telephone

Home Phone _____ Work Phone _____ Ext. # _____

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-payments at the time of the procedure. Please make financial arrangements prior to procedures.
2. A charge of \$50 will be charged for any returned NSF checks.
3. We reserve the right to charge for broken or cancelled appointments without 48 hours notice.

Dental Insurance Information

Primary Insurance

Name of Insurance Company _____
Name of Insured _____ Insured's birthdate _____
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 birthdate _____
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 Lairy W. Miller, D.D.S. 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 **Lairy W. Miller, D.D.S.** 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 OF YOUR CHARGES, AND YOU ARE RESPONSILBE 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