Personal Information:

Name: ____
Last First M.I. Preferred Name

Date of Birth: _____/______/______

Sex: Male ☐ Female: ☐

Mailing Address:____

City:____

State:_________ ZIP:______________

E-Mail: ____

Home Phone: (______)_______________ Cell Phone: (______)___________

Dental Insurance information:

We Are In-Network with Delta Dental and Premera Only

Primary Insurance: ____

Person Responsible for the Account: ________________________________

Relation to Patient: ____

Subscriber Date of Birth:_____/______/______

Subscriber ID (OR Social Security Number): ___________________________

Group Number: ____

Medical & Dental Information:

Primary Physician:____________________Phone: (_____)________________

Date of Last Physical Exam: _______________________________________

Emergency Contact:___________________________Relation:____________

Emergency Contact Phone #:(______) ___________ ___________

Dentist:________________________________ Date of Last Exam:_________

Insurance Coverage

Dear Patient:

As a courtesy, our office is here to help assist you with your dental insurance claims. If your dental insurance requires a "Pre-Determination", our office is able to submit one after your initial exam, at your request. Please understand "Pre-Determination" is NOT a guarantee from your insurance provider of payment. Dental insurance coverage of treatment is between you, your employer (if Applicable), and your insurance provider. Please remember, we are here to assist you in the submitting of claims, however, the financial obligation rests with you.

If you decide to proceed with treatment and your insurance provider is out of network, out of network fees may apply. We will provide you a treatment plan after your first exam with the dental description and dental codes. These can be helpful in assisting you to obtain information from your dental company when you look into your dental coverage.

If you have question about your dental coverage or your procedure, please ask us and we will help as best we can. You are also encouraged to contact your insurance provider directly to discuss coverage prior to your procedure.

We will help in every way to file your claims, handle insurance inquiries, investigate lost claims, and the like. No question is too small for you to ask regarding your treatment or your insurance benefits.

Sincerely,

Dr. Laura Cardenas and Staff

__________________________________ ___________

Patient Signature Date

____

Print Patient Name

Financial Policy

When you make any decision regarding dental treatment, it is important that you understand the financial decision you are making at the same time. We are committed to fully informing every patient every time of their financial responsibility prior to treatment.

You are responsible for the cost of treatment provided in our office. If you have a dental plan, we will work with you to understand your anticipated benefits as they apply to your treatment choices.

- Initial exam charges are due at the time of service or will be billed to your insurance if applicable.
- Total estimated cost of treatment will be given to you after your new patient exam.
- Our office requires a 48 Hour notice for all cancellation to avoid a cancellation fee.
- At the time of service, 50% of the patient's portion of the procedure cost is due; the remaining balance can be broken into two payments. 25% at the first post-op appointment and the remaining 25% at your final post-op appointment.
- We accept VISA, MASTERCARD, DISCOVER, CARECREDIT and Cash or Check.

Your dental treatment is important to your health. We always welcome questions you have about dental care and the costs of care. We are committed to you and to the treatment and payment option that is right for you.

I, ___________________________________ (print patient's name) agree to the above policy. I am aware that a payment of 50% of the total balance of the estimated patient portion is due on the date of the procedure and the remaining balance of my account is to be paid in full by my final post-op appointment.

_______________________________________ _________________

Patient's Signature Date

Notice of Privacy Practices
Acknowledgment

We keep a record of the services we provide you. You may ask to see and copy that record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Other health care providers may ask to see your records.

I have received a copy of this office's NOTICE OF PRIVACY PRACTICS as required by federal law and consent to the use and disclosure of my personal health information by your office during Treatment, Billing/Payment and Dental Office Operations as outlined in the Notice of Privacy Practice.

____ ________________

Signature of Patient *Date*