Alameda
DENTAL CARE
Healthy Smiles for a Lifetime

Who may we thank for referring you to our office? _____ Today's Date_____

Patient Information

Patient Name: _____Preferred Name: _____ Date of Birth: _____ Gender: M/F

Mailing Address: _____ City: _____State: _____ Zip: _____ SS#: _____

Home Phone: _____Work Phone: _____Cell: _____ Marital Status: _____

E-Mail: _____@_____ Employer: _____Occupation:_____

Employer Address: _____ Employer Phone: _____

Emergency contact: _____Relationship: _____Phone: _____ Phone: _____

Primary Insurance Information

Subscriber's Name: _____Date of Birth: _____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St: ____ Zip: _____ Phone:_____

Secondary Insurance Information

Subscriber's Name: _____Date of Birth: _____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St: _____ Zip: _____ Phone:_____

Would you like email and text message reminders? Email Y / N - Text Y / N

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA. I acknowledge that I have been offered a copy of Alameda Dental Care Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name _____ Signature _____

Relationship to Patient_____ Date _____

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OFFICE POLICY

Welcome to Alameda Dental Care! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. Initials_____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial down-payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

Copyright: Any comment posted online in any way relating to Alameda Dental Care, doctors or employees will be the sole right and property of Alameda Dental Care and the copyright of the content of the comment, rating, or review is hereby assigned to Alameda Dental Care to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. We appreciate public praise and comments and reviews.

Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit or CitiHealth. Initials_____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Alameda Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. Initials_____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 per hour. Initials_____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Alameda Dental Care.

I have read, understand, and agree to the above.

_____
Signature of Person Responsible for Account

_____ _____
Printed Name of Person Responsible for Account Date