CODY
DENTAL EXCELLENCE

WELCOME TO THE PRACTICE OF
DR. DEVON HOLEMAN, DMD

PLEASE TAKE A MOMENT TO LET US KNOW HOW YOU HEARD ABOUT US

POSTCARD MAILER ☐ **NEWSPAPER** ☐ **RADIO** ☐ **INTERNET**

IF A PATIENT OR FRIEND RECOMMENDED US LET US KNOW SO WE CAN THANK THEM_____

COURTESY REMINDERS

WOULD YOU LIKE TXT MESSAGE REMINDERS? **YES OR NO** VERIZON AT&T SPRINT NET10 TMOBILE

EMAIL REMINDERS? **YES OR NO** EMAIL ADDRESS:_____

DENTAL INSURANCE *PLEASE DISREGARD THIS SECTION IF YOU DO NOT HAVE INSURANCE*

PLEASE CHECK WITH RECEPTIONIST WE MAY ALREADY HAVE THIS INFORMATION ON FILE

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME_____ SS#/SIN_____ BIRTHDATE_____

INSURANCE COMPANY_____ GROUP NUMBER_____ POLICY NUMBER_____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME_____ SS#/SIN_____ BIRTHDATE_____

INSURANCE COMPANY_____ GROUP NUMBER_____ POLICY NUMBER_____

WRITTEN FINANCIAL POLICY

PAYMENT FOR DENTAL TREATMENT IS DUE AT THE TIME OF TREATMENT.

Payment Options: Cash, Check[1], Visa, MasterCard, American Express , Discover Card, CareCredit

[1]In the event your payment is made by check and for any reason your check is returned, you are responsible for the cost of treatment, bank fees and all other costs associated with collection of a debt.

CareCredit offers payment options with deferred interest for qualified patients. (Subject to credit approval)
*There are no annual fees or pre-payment penalties through CareCredit [1]If paid within promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
Payment **plans are offered through CareCredit only.**

Patients with dental insurance we are happy to submit your dental claims as a service to our patients. We will help you maximize your benefit and electronically submit claims for reimbursement. However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment. You may then pursue your benefits and collect directly from your insurance carrier. ***An estimated patient responsibility will be determined at your visit, however it is an estimate only, you are responsible for any amount not paid by your carrier.***

X Patient, Parent, or Guardian Signature **X** Date