

PATIENT INFORMATION

Welcome to our office. Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare office records.

Please complete this portion only if you have dental insurance.

Patient Name: _____ Date of Birth: _____

Subscriber: _____ Date of Birth: _____

SS#: _____ ID#: _____ Group#: _____

Insurance Company: _____ Phone No: _____ Employer: _____

I authorize the release of any information needed to process insurance claims. This office uses electronic claims for filing insurance. I also authorize payment of benefits directly to Clayton R. Davis, D.M.D. I understand that I am financially responsible for the charges not covered by this authorization.

Signed: _____ Date: _____

In compliance with the TRUTH IN LENDING LAW, here is our credit policy: It is customary to take care of the fee at the time services are rendered unless other arrangements have been made. We accept major credit cards. If you wish to make any other type of financial arrangements, please discuss this with a member of our business office staff prior to beginning treatment.

As a courtesy, our office asks that you please give us a 48 hours notice if you must reschedule an appointment. This makes it possible to give your reserved time to another patient wanting to see Dr. Davis or our hygienist. Unfortunately due to the demand for our appointment times, we will not be able to give another appointment time to any patient who cancels with less than 48 hours notice on 3 different occasions.

If you have dental insurance, as a courtesy to you, we will assist in filing your insurance claims and will accept assignment of benefits from your carrier. In return, we ask that you be aware of the following:

1. Today's dental insurance is not designed to be a "Pay All". It is merely a benefit to aid in paying some portion of your dental expenses. Some routine dental services are not covered at all by dental insurance. We have found that coverage can vary greatly from one plan to another.
2. Patient deductibles will have to be met at the time services are begun unless previously satisfied.
3. That part of treatment not covered by insurance (patient co-payment) is to be paid at the time of service unless other arrangements have been made in advance. Our staff will advise you of the estimated charges prior to your treatment if you wish to know your estimated portion.

While we are pleased to offer this service. Acceptance of insurance assignment by our office does not relieve the patient of ultimate responsibility for the fees incurred. Claims pending more than 60 days should be paid by the patient and reimbursed by the carrier.

After 60 days, any remaining balance will accrue a monthly interest charge until the balance is paid in full.

I certify that the above information is true and accurate to the best of my knowledge and agree to the credit policy as listed above.

Signed: _____ Date: _____