BAY AREA SPECIALISTS IN
CONTEMPORARY PROSTHODONTICS

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Patient Information

Today's Date ____________________

Patient Name First ____________________________ MI _____ Last __________________________ Nickname _________________

Address Street ________________________________ City ___________________________________ State ________ Zip __________

Phone Home _________________________________ Work __________________________________ Mobile ___________________

E-mail Address ____

May we contact you with any of the above listed information Yes _________ No _________, do not use ___________________

Social Security Number ____ **Date of Birth** ________________________________

Drivers License # ____ **State** _____________________________________

Employer _________________________________ **Occupation** _____________________________ **Phone** ___________________

Work Address Street ________________________ City ____________________________________ State _________ Zip _________

Sex: Male | Female **Marital Status:** Single | Married | Divorced | Separated | Widowed

In case of an emergency, who should be notified ? ____

Relationship of ER person to Patient ___________________ **Home Phone** ____________________ **Mobile Phone** _____________

Other Family or Friends who are Patients in Our Practice ____

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Is Patient a Minor? Yes _________ No ________ (*If no*, please skip to the following "Dental Benefit Plan Information" section)

Full time Student? Yes _________ No ________ **School** ____

Name of Responsible Party First _________________________ Last ____________________________ **Date of Birth** _____________

Relationship to Patient: Self | Spouse | Parent | Other ____

If Patient is a Minor, Primary Residency: Both Parents | Mom | Dad | Step Parent | Shared Custody | Guardian

Address (if different from patient) Street _________________________ City ______________________ State _______ Zip _________

Phone Home _____________________________________ Work _____________________________ Mobile _____________________

Employer (if different from above) ____________________**Occupation** _______________________ **Phone** ____________________

Address Street ____________________________________ City ______________________________ State ________ Zip __________

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Dental Benefit Plan Information

Primary Dental Plan Name ____ **Phone** ______________________

Address Street ________________________________ City ________________________________State _________ Zip ______________

Name of Insured ______________________________ **Date of Birth** _______________________ **SSN** ____________________

Employer________________________**Group #**_______________________**Patient Relationship to Insured** ____________________

Secondary Dental Plan Name ____ **Phone** _________________________

Address Street ________________________________ City ________________________________State _________ Zip ______________

Name of Insured ______________________________ **Date of Birth** _______________________ **SSN** ____________________

Employer________________________**Group #**_______________________**Patient Relationship to Insured** ____________________

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Medical Plan Information

Plan Name ____ **Phone** ______________________

Address Street _________________________________ City _________________________________ State _________ Zip ____________

Name of Insured ______________________________ **Date of Birth** _________________________ **ID Number** __________________

Policy Number ________________________________ **Patient Relationship to Insured** ______________________________________

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Referral

Whom may We Thank for Referring You ?

________ One of our valued patients (name of patient) ____

________ Another doctor (name of referring doctor) ____

________ Dental Society or Organization (specify) ____

________ Our Website

________Advertisment/Other (specify) ____

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Office Policies and Federal Truth-In Lending Statement

Patient Responsibilities - We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payments - *Payment is due at the time services are rendered*. Financial arrangements are discussed during the consultation stage and a financial agreement is completed in advance of performing any treatment with our practice. Any dental service performed without previous financial arrangements, must be paid for at the time services are rendered. We currently only accept *cash or check* from the patient and other third party financing can be discussed as needed. A service charge of 1.5% per month (18% per annum) on the
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unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of four months from date of the financial agreements are discussed.

Financial Breaches - Returned checks will be subject to a *$50 returned check fee* and will result in possible cash only transactions with future visits. Please let us know if you need us to hold any checks before depositing within a reasonable time frame. In consideration for the professional services rendered to me, or at my request for my minor child by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter. Unpaid balances shall also be subject to a data transfer of derogatory information about any unpaid balance to major credit bureau reporting agencies(Experian, Equifax, etc).

Dental Benefit Plans and Insurances - Your dental insurance is a contract between *you or your employer* and the dental benefit plan. Benefits and payments received or paid are based on the terms of the contract negotiated between you or your employer and the plan. The dentist or the dental practice has nothing to do with your negotiated contract. Our dental practice is *NOT* a contracted provider with any dental benefit plans. It is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from "out-of-network" providers. If your plan allows reimbursement for services from out-of-network providers, our practice can help submit the claims to them. Disputes in regards to any insurance reimbursement will be a matter that is between the patient and their insurance company only. You are responsible for services rendered in our office and responsible for payment before or at the time of service and as outlined in your financial agreement contract if applicable. We are however, happy to help our patients with their dental benefit plans to understand and maximize their coverage.

Scheduling of Appointments - We reserve time for each patient procedure and are diligent about being on-time yet spending enough time on each patient. Because of this courtesy, when a patient is tardy or cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $75 or deposit to reserve that appointment time again, may be required. If this notice is less than 24-hours, the fee will be increased to $150 to reserve the next appointment. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $75 or deposit to reserve the appointment time again, may be required. For patients that do not show up for their appointment completely, we reserve the right to charge them a fee of *$150 for the time that was allocated to them*. Due to the large amount of time involved in prosthetic treatment, other patients who may wish to take your appointment time require several days notice in order to accommodate their schedules.

Authorizations - Please initial the following after reading and asking any questions.

_____ I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during the consultation or the diagnosis stage.

_____ I have read the above and agree to the financial and scheduling terms.

_____ I authorize the release of information necessary to process my dental benefits claims and have the reimbursements be distributed to me directly if applicable.

_____ I hereby acknowledge that a copy of this practice HIPAA Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ I hereby give consent for the doctors/staff to take and/or display photographs of my face, teeth, and smile. The photographs will be used for educational and/or advertising purposes by our doctors and maybe displayed in our office, our webpage, as well as any lectures given by our doctors. My personal data (ie., name, age, date of birth, etc) will not be displayed.

_____ I hereby acknowledge that a copy of this practice Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Signature below is acknowledgement that everything I have provided above is true to the best of my ability and that I have read through all details and asked any related questions until I fully understand everything within this agreement.

Print Name_____ **Signature** _____ **Date** _____