PATIENT INFORMATION

Patient Name ____ Date of Birth __________________

Person Responsible for account__________________________________ Relationship to patient________________

Address ____ City____________________ State_____ Zip__________

Phone Numbers: Home ______________________ Cell _______________________ Work _______________________

Preferred phone contact (please circle) Home Cell Work Social Security #_______________________________

Employer___________________________________ Occupation ____

Referring Dentist ____ City___________________________________

Emergency Contact Name_____________________________________ Phone_______________________________

PRIMARY INSURANCE INFORMATION

Person Responsible for account________________________________ Relationship to patient_________________

Insured's date of birth ________________________________ Social Security # _______________________________

Dental Insurance Carrier_______________________________________ Phone _________________________________

Address___________________________________ City____________________ State ________ Zip______________

Group #___________________

SECONDARY INSURANCE INFORMATION

Person Responsible for account________________________________ Relationship to patient_________________

Insured's date of birth ________________________________ Social Security # _______________________________

Dental Insurance Carrier_______________________________________ Phone _________________________________

Address___________________________________ City____________________ State ________ Zip______________

Group #___________________

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We never want you to be surprised about the cost of your treatment. Please verify the approximate cost of your treatment prior to being seen. You will be responsible for payment at the time of treatment. We accept cash, checks, Visa, MasterCard, Discover, and CareCredit.

For patients with insurance coverage, copayment is due at the time of treatment. We are happy to assist you in filing your dental insurance claim. We will give you our best estimate we are able to determine from your insurance provider; however, **please understand that our calculations are strictly ESTIMATES and there is no guarantee that your insurance company will reimburse us according to these estimates**. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. You are responsible for any portion of the treatment fee that your insurance company does not pay, for any reason.

A finance charge is computed at a periodic rate of 1.5% monthly (annual percentage rate of 18%) on any unpaid balance over 90 days. A fee of $35 will be charged for all returned checks. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

I have read the Financial Policy and understand my financial responsibility for dental services provided. I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Beavercreek Endodontics-Emily Lammers, DDS, MS, Inc. and authorize release of any information relating to a claim.

Signature____ Date _________________________

ACKNOWLEDGEMENT AND CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

I have read and understand the Notice of Privacy Practices.

Signature ____ Date ________________________