

Rifle Dental Care

Patient Information

Patient Name: _____ Date: _____

Male Female Married /Single Child

Address:

Street /Apartment # _____

City _____ State _____ Zip Code _____

Social Security _____ BirthDate: _____

Driver's License #: _____ State: _____

Phone (Home): _____ (Cell): _____

Work/Other phone: _____

Email address (for appointment confirmations) _____

Emergency Contact: _____ Phone _____

Health Information:

Date of last dental visit: _____

Reason for today's visit (circle all that apply): **Loose teeth** **Broken fillings** **Sensitivity**

to biting **Sensitivity to heat** **Sensitivity to cold** **Concerned about my smile**

Swollen/bleeding gums **Bad breath** **Clicking or popping jaw**

Other: _____

Signature _____

Patient/parent/guardian

Whom may we thank for referring you to Rifle Dental Care?

Rifle Dental Care

Responsible Party Information

Refers to the person who is responsible for payment

Name: _____

Self Spouse Parent/guardian

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Work: _____ Ext. _____

Address:

Street /Apt # _____ City State Zip _____

Employment Information:

Employer Name: _____ Occupation: _____

Address: _____

Insurance Information:

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name:

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (and/or my dependent) have coverage with _____ and assign payment of benefits directly to doctor for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship to Patient _____ Date _____

UNDER-AGE TREATMENT

For liability reasons, patients under the age of 18 must be accompanied by a parent or legal guardian to ALL dental appointments. If someone other than a parent or legal guardian will accompany the patient to appointments, the parent or legal guardian MUST sign a consent form prior to treatment.

FINANCIAL STATEMENT

Our office makes available several payment options for your dental care. Payment or outside financing arrangements are ALWAYS due at the time of service. A 5% discount is available when paying with cash or check. Payments made with Visa, MasterCard, American Express, and debit cards are accepted. Outside financing options are available. Financing applications must be completed and approved prior to receiving dental treatment.

INSURANCE

Our office will file your primary dental claim as a courtesy. The out-of-pocket portion of your treatment is always due at the time of service. All claims will purge from our system after 45 days. **All unpaid insurance balances over 45 days are the patient's responsibility, to be paid in full immediately.**

I understand I am responsible for my account regardless of my insurance. I also understand that my policy is an agreement between me and my insurance company. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I understand that these records may be used for educational purposes.

Patient's Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Please print name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement cannot be obtained because:

- Individual refused to sign
- Communication barriers prohibited us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (please specify)

