Patient Agreement

THANK YOU

Thank you for choosing us for your dental care. We appreciate the opportunity to meet you and to serve your dental needs. The following is general information we need you to be aware of for us to best serve you.

HEALTH HISTORY/MEDICATION LIST

It is well established that your dental health and systemic health are connected. It is imperative that we know about certain health conditions that you may have. Many medications can affect oral health. We ask you to assist us with your care by providing current health and medication information. (If you take a number of medications, you may prefer to bring a list of your medications and dosages to your first appointment.) This will be updated at future appointments.

_____(initial)

INSURANCE BENEFITS/FINANCIAL RESPONSIBILITY

Dental insurance is intended to cover some, but not all, of the care you may need. Most insurance policies include co-payments, deductibles and an annual maximum. There will almost always be other limitations and exclusions specific to individual policies. We will do our best to estimate your out-of-pocket portion. Exact out-of-pocket portions can never be determined until insurance payments are received. Your final balance may differ from the estimate. Any account credits may be refunded at your request or applied to future services. Statements for remaining balances are mailed following receipt of your insurance payment and expected to be paid in full unless other arrangements have been made. We accept cash, check, money order, Visa, MasterCard, Discover and American Express. We also accept Care Credit and will be happy to assist you in establishing a Care Credit account.

_____(initial)

OUR REQUEST REGARDING APPOINTMENTS

We respect your time and work really hard to stay on schedule. We hope you will understand and respond by giving a minimum of 24 hour notice if you must change an appointment. This allows us to make time available to patients with immediate needs. We reserve the right to charge a $50 broken appointment fee to offset the cost of unused staff time. This is intended to discourage repeated abuse of our schedule and not to penalize patients who have illness or other unexpected emergencies. If you are late for an appointment, circumstances may require that we reschedule your appointment.

_____(initial)

PRIVACY PRACTICES

Our privacy practices are posted in our office as required by law. We will use your personal health information only as necessary for treatment, payment and healthcare operations. This information will not be used for marketing or any other purpose. **If you wish for us to discuss your dental care with anyone else (spouse, guardian, responsible party, etc.) you must provide us their name and relationship in the space below.**

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_____(initial)

NOTE:

Again, we thank you for calling our office. We are happy to provide you the best information we can regarding your treatment. We encourage you to ask questions. I have read and understand the information above.

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Patient (Legal guardian) Signature Print Name Date

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