

PATIENT QUESTIONNAIRE

DATE _____

NAME _____ SEX _____	SSN _____
ADDRESS _____ MARITAL STATUS _____	PERSON FINANCIALLY RESPONSIBLE FOR ACCT
CITY _____ ST _____ ZIP _____ DOB _____	_____
HOME PHONE _____ CELL _____ AGE _____	(name) (relationship)
EMAIL _____	(address)
EMPLOYER _____	DO YOU HAVE DENTAL INSURANCE Y N
WORK PHONE _____	POLICY # _____
OCCUPATION _____	POLICY HOLDER:
HOW WHERE YOU INSURANCE _____ INTERNET _____ OTHER _____	_____
REFERRED? ANOTHER PATIENT (Name) _____	SSN _____
CURRENT PHYSICIAN _____	RELATIONSHIP TO PATIENT _____
PREVIOUS DENTIST _____	PLACE OF EMPLOYMENT FOR POLICY HOLDER
EMERGENCY CONTACT:	_____
NAME _____	(name)
ADDRESS _____	(address)
PHONE # _____	(city, state, zip)
	(phone)

PAYMENT FOR SERVICES

Payment for services is required at the time services are rendered, unless other arrangements are made prior to treatment. How will you be paying for your dental treatments?

CASH _____ CHECK _____ CREDIT CARD _____ INSURANCE _____

I assign my insurance benefit to Dr. Taylor and authorize payment for service directly to her. (SIGN BELOW)

Signature: _____ **Date:** _____

OUR POLICY ON INSURANCE

This office will submit your insurance claims for you, if you direct the insurance company to pay its share of the cost directly to the office (assignment of benefits). At the time of service, we may give you an estimate of amounts we expect your insurance to pay and then may require that you pay your estimated co-pay at that time. Though we state estimates, you are responsible for knowing how your insurance works. Upon receipt of the insurance payment, we will reconcile the account and bill or refund you any difference. **You remain responsible for the total cost of dental services, and at any time we may require full payment from you.**

CANCELLATIONS

We require 24 hour notice when you cancel an appointment, thus allowing this office to give that appointment to another patient. **Cancellations with less than 24 hour notice will result in a charge of \$35 per hour for the scheduled appointment.**

ADDITIONAL CHARGES

Charges incurred by Dr. Taylor for NSF checks or to recover unpaid debts **will be added to my balance.** This includes collection agency fees (ranging from 35% to 50% of the balance due) and attorney's fees. Interest shall accrue at 18% per annum.

******* I HAVE READ AND UNDERSTAND THE TERMS STATED ABOVE *******