PATIENT QUESTIONAIRE

DATE_____

NAME _____ SEX_____

ADDRESS_____ MARITAL STATUS _____

CITY_____ST_____ ZIP_____ DOB _____

HOME PHONE _____ CELL_____ AGE _____

EMAIL _____

EMPLOYER_____

WORK PHONE _____

OCCUPATION _____

HOW WHERE YOU REFERRED? INSURANCE _____ INTERNET _____ OTHER _____

ANOTHER PATIENT (Name)_____

CURRENT PHYSICIAN _____

PREVIOUS DENTIST _____

EMERGENCY CONTACT:

NAME _____

ADDRESS_____

PHONE # _____

SSN _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCT

_____
(name) (relationship)

_____
(address)

DO YOU HAVE DENTAL INSURANCE Y N

POLICY # _____

POLICY HOLDER:

_____

SSN_____

RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT FOR POLICY HOLDER

_____
(name)

_____
(address)

_____
(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 *******

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