

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL				
Name _____				
Last		First		MI (Preferred)
Birthdate _____		SS# _____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F Married: <input type="checkbox"/> Y <input type="checkbox"/> N
Work Phone _____		Wireless Phone _____		Wireless Carrier _____
Email _____				
Preferred contact method		<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email		
Preferred contact method for confirmations		<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email		
Preferred contact method for recall		<input type="checkbox"/> HmPhone <input type="checkbox"/> WkPhone <input type="checkbox"/> WirelessPh <input type="checkbox"/> Email		
Student status if dependent over 19 (for ins) <input type="checkbox"/> Nonstudent <input type="checkbox"/> Fulltime <input type="checkbox"/> Parttime				
How did you hear about us? _____				
(If someone referred you here, please write down their name so we can thank them.) _____				
ADDRESS AND HOME PHONE				
Check box if same for entire family <input type="checkbox"/>				
Address _____				
Address 2 _____				
City _____		State _____	Zip _____	
Home Phone _____				
INSURANCE POLICY 1				
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child				
Subscriber Name _____		Subscriber ID # _____		
Insurance Company _____		Phone _____		
Employer _____		Group Name _____	Group # _____	
Please present insurance card to receptionist.				
INSURANCE POLICY 2				
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child				
Subscriber Name _____		Subscriber ID # _____		
Insurance Company _____		Phone _____		
Employer _____		Group Name _____	Group # _____	

Comments:

DENTAL INSURANCE CLAIM PROCESSING POLICY:

Because dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role.

It is your dentist's responsibility to recommend what you need. All recommendations are based on diagnostic (x-rays) and clinical picture and presented to you by your dentist or by the office manager. Your dentist will give you options (if any) for the treatment recommended, will answer all questions you might have about it and will help you to decide what treatment would be the best for you.

When your office visit is completed, the receptionist will enter the charges into the computer. You will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.

If you carry a supplementary or secondary Insurance Plan, we will help you with both Insurance claims, but we still will follow our Policy to collect deductible, coinsurance, pre-payment. Your overpayment, if any, will be returned back to you after secondary claim will be cleared, in the form of original payment.

If you are interested in following the doctor's recommendation and need to know exactly how much your Insurance plan will pay for it, a pre-treatment estimate will need to be filed. We will file a patient treatment pre-estimate to their primary insurance upon the patient's request before the treatment is begun.

We will send a dental claim on your behalf and we will answer any questions your Insurance Company may raise about diagnosis or treatment in an appropriate, timely manner. It is important that you understand we are not part of the relations between you and your Insurance. If insurance denies benefits for patient's treatment for any reason, the patient is financially responsible for all charges and for outstanding balance on the account. We are unable to "force" an insurance company to fulfill its obligations to you.

If the insurance company does not pay for your treatment in a reasonable period of time (more than 2 months) patient is responsible to pay the balance off. All credits if any will be returned to the patient upon receiving final payment from the insurance.

We would love to keep you happy and helping you to accept a recommended treatment by providing an assistance with your benefits. There is a way to help, but it does not include taking on total responsibility for the decisions of your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED by Westphalia Dental.