Welcome

PATIENT INFORMATION
Patient Full Name _____
Birth date _____ SS# _____
Relationship to Insured _____

FINANCIALLY RESPONSIBLE PERSON/S INFORMATION
Full Name _____ Birth _____
Address _____
City _____ State _____ Zip _____
SS# _____ Driver's Lic. # _____
Phone (h) _____ (m) _____
Email Address _____
Employer _____ Ph. (w) _____
Spouse's Name _____ Birth _____
SS# _____ Driver's Lic. # _____
Employer _____ Ph. (w) _____

WHOM MAY WE THANK FOR REFERRING YOU?
❑ Friend ❑ Relative ❑ Work Colleague ❑ Dentist ❑ Internet
❑ Yellow Pages ❑ Newspaper ❑ Insurance Co. ❑ Other
Referrer's Name _____
Which Yellow Pages _____
West56thDental.com Yes No

PRIMARY DENTAL INSURANCE
Insurance Company _____
Insurance Group# _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Co. Phone# _____

SECONDARY DENTAL INSURANCE
Insurance Company _____
Insurance Group# _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Co. Phone# _____

INSURANCE CLAIMS AND COVERAGE
Our goal is to help maximize your dental benefits. Please remember that the benefits available under the terms of your dental contract have been determined by your employer and your insurance carrier. Your dental care is based on proper dental therapeutics, not on an insurance company's benefit package. This dental office treats patients with hundreds of different insurance plans and benefit structures. We cannot accurately predict before or during treatment what will be paid (if any) on your claims. Please remember the dental office does not retain a copy of your explanation of benefits (EOB).

APPOINTMENT CANCELLATION GUIDELINES
When you reserve an appointment at West 56th Dental we have blocked that time specifically for you. If for some reason you are unable to come to your reserved appointment, we require 48 hours notice. If you miss your appointment or do not contact us within 48 hours prior to re-schedule, you are subject to a charge of $50.00 per hour for your missed appointment. By signing below, I agree to the appointment cancellation guidelines.

Patient Signature _____

DENTAL HISTORY
Former Dentist _____
City _____ St _____ Ph# _____

When was your last dental visit? What treatment was done?

What is the main reason for your dental visit today?

What is the most important thing to you about your dental health?

DO YOU LIKE YOUR SMILE? Yes No

WHAT WOULD YOU CHANGE ABOUT YOUR SMILE?
❑ Make my teeth whiter
❑ Make my teeth straighter
❑ Close spaces between my teeth
❑ Replace black metal fillings w/ tooth-colored restorations
❑ Repair my chipped teeth
❑ Replace my missing teeth
❑ Replace my old crowns that don't match
❑ Have a smile makeover

TREATMENT OF CHILDREN
Know we have your child's best interest in mind, and we will give them the best possible care. Through years of treating children, we have found when they get acquainted with our staff and their surroundings they have a positive dental experience. We have also found when parents accompany their children in treatment rooms, children are less apt to interact with us. For this reason we've made it our office policy that parents not be present in the treatment room. We ask for your confidence in this decision. Please feel welcome to walk your child back to their chair and/or have a tour of the office at any time.

OWNERSHIP OF RADIOGRAPHS
The Utah State Dental Practice Act requires all appropriate records of treatment rendered to a patient (including radiographs) must be established and maintained by the dentist for a period of seven years. Consequently, we cannot release the original records including radiographs. Duplicate radiographs can be furnished upon request with the associated duplication fee.

DISCLAIMER
I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. I authorize release of information to insurance carriers to collect on my behalf. I authorize my insurance company to make payment directly to West 56th Dental. I acknowledge I have received a copy of this office's Notice of Privacy Practices. I agree to disclose to the dentist names of individuals with whom I authorize the dentist to discuss my health care. I understand that the information I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes.

Responsible Party Signature _____
Today's Date _____

WEST 56TH DENTAL
Family • Cosmetic • Implant Dentistry

Payment Options

Our goal is to provide excellent dental care for you and your family and provide assistance in managing your dental needs. West 56th Dental offers convenient payment options while at the same time maintaining the high standard of comprehensive dental care you deserve. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient, and that he or she is personally responsible for payment of all services. We are happy to submit insurance forms to the insurance company designated. We will credit all collections received to the designated account. However, this dental office cannot render services on the assumption that our charges will be paid in full, or portion by an insurance company. We cannot make insurance companies render payment for services. Your estimated portion is due in full the day of treatment, and then we will process your insurance claim.

At the onset of treatment, we will provide you with an estimate of the total fees expected. Please understand this will only be an **estimate**. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

Please take a moment to review the financial plans and **INITIAL** in the box, (**do not check**), your preferred form of payment.

☐ Plan A: Prepayment Courtesy
We offer a 5% bookkeeping courtesy for all treatment that is paid in full prior to the day of treatment.

☐ Plan B: Payment as services are rendered
I prefer to pay at the time of service with cash, check, credit, or debit card. We gladly accept MasterCard, Visa, and Discover Card.

☐ Plan C: Monthly Payment Plans
We have arranged with various lending institutions to provide short (6 months interest free) and long term financing (up to 60 months). Financing is available upon credit approval. **By checking this box, you authorize one of our team members to obtain your credit report and assist you with the application process. **

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In consideration for the professional services rendered to me, (or at my request to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time said services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of 40% to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I understand there will be a $30 charge on all returned checks. I understand after one check is returned, the only method of payment this office will accept is cash or credit card. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made**,** and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

A monthly service charge at a fixed rate of 1½% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination. I authorize my insurance company to make payment directly to West 56th Dental for services rendered and agree to pay any remaining unpaid portion within 60 days from the date of the service. I understand that I will not be assessed finance charges during this 60 day grace period for receiving my insurance payment.

I grant my permission for West 56th Dental to contact me at home or at my place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior arrangements signed, including any and all mediation/arbitration agreements. I acknowledge that any prior agreements related to financial arrangements or quality of care are null and void. I hereby agree to abide by the condition outlined herein.

Responsible Party Signature _____

Today's Date _____

WEST 56TH DENTAL