Patient Information Form

Patient Name: First_____ MI _____ Last_____ Preferred _____

Address: Street_____ City_____ State _____ Zip _____

Phone: Home _____ Work_____ Mobile _____

Social Security Number: _____ **Date of Birth** _____ **Sex** ☐Male ☐ Female

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Patient Employed By _____Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip_____

In case of emergency, who should be notified? _____ Home Phone _____Mobile Phone _____

Dental Benefit Plan Information

Dental Insurance Carrier Name: _____

Name of Policy Holder _____ Date of Birth _____ ID Number or SSN: _____

Policy Number _____

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) _____

☐ Post card (mail) ☐Newspaper Advertisement ☐Insurance ☐Our Website ☐Other_____

EMAIL Communication and Your Privacy

Unencrypted email is not a secure form of communication. There is some risk that any individual identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is:
_____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is:
_____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Financial & Scheduling Responsibilities

We are committed to providing you with the best possible care; toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, CREDIT/DEBIT Card, & CareCredit Financing. **Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Sycamore Dentistry IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We are diligent about being on-time, because of this, we do require 48-hour notice to reschedule an appointment.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____(initial)

Signature _____ Date_____