# Bridgetower Dental

Name: _____ Prefer to be called: _____
*First* *MI* *Last*

DOB: _____ Age: _____ SS#: _____ Marital Status: _____ [ ] M [ ] F

Home Address: _____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City/State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse or Parent's name: _____ SS#: _____ Day Phone: _____

Employer: _____ Relationship to Patient: _____

Whom may we notify in case of an emergency: _____ Phone: _____

How did you hear about our office? _____

E-MAIL: _____

Preferred method of contact for appointment reminders: [ ] E-mail [ ] Text message [ ] Voice call

## INSURANCE:

**PRIMARY:** Employee's name: _____ DOB: _____ SS#: _____

Employer: _____ Phone: _____ ID#: _____

Group#: _____ Insurance Co: _____

Ins. Co. Address: _____ Ins. Co. Phone: _____

**SECONDARY:** Employee's name: _____ DOB: _____ SS#: _____

Employer: _____ Phone: _____ ID#: _____

Group#: _____ Insurance Co: _____

Ins. Co. Address: _____ Ins. Co Phone: _____

## FINANCIAL – APPOINTMENT – MEDICAL – INSURANCE RELEASE:

The information I have given today is correct to the best of my knowledge. I acknowledge the following:

1. I have been advised of the HIPAA Notice of Privacy Practices provided by this office.
2. I will hereby advise the office of any and all changes to my medical history at each appointment.
3. I hereby authorize direct payment from my Insurance Company to BRIDGETOWER DENTAL and further authorize release of any and all information requested by said insurance company for processing my claims.
4. Insurance claims are filed as a courtesy on the part of the dental office; if I feel that the insurance company has not paid correctly, it is my responsibility to contact them. The dental office will be happy to provide any paperwork necessary to help me settle any disputes with my insurance company.
5. I am financially responsible for all charges, regardless of my insurance coverage. I also realize that it is my responsibility to be familiar with my insurance policy and to immediately notify the office of any changes therein.
6. Payment is due AT TIME OF SERVICE; if I have insurance, any and all copayments and/or deductibles are due at time of service. I can pay by cash, check, credit card, or CARECREDIT.
7. If I refuse to provide my social security number, I agree to pay IN FULL with credit card or cash, regardless of my insurance status.
8. In accordance with the Federal Truth-In-Lending Act; I realize that any balance older than 60 days may be subject to a billing charge of $5.00 per month or finance charges of 21% APR, whichever is greater.
9. If I am unable to keep a scheduled appointment, I will give the office **24 HOUR NOTICE.** All appointments are confirmed by E-mail correspondence, text, and or phone whenever possible and it is my responsibility to inform the office of any and all current phone numbers. A $50.00 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS.

_____ Date: _____
Responsible Party Signature