desertpearl
DENTISTRY

PATIENT INFORMATION AND FINANCIAL POLICY

CELL PHONE:_____

DATE:_____ HOME PHONE:_____

NAME:_____ NICK NAME:_____

AGE:_____ BIRTH DATE:_____ EMAIL:_____

MAILING ADDRESS:_____ CITY:_____ ZIP:_____

EMERGENCY CONTACT NAME:_____ PHONE:_____

EMPLOYER/OCCUPATION:_____ SOC. SEC. NO.:_____

BUS. ADDRESS:_____ BUS. PHONE:_____

SPOUSE/PARENT NAME:_____ EMPLOYER:_____

BUS. ADDRESS:_____ BUS. PHONE:_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

IS PATIENT COVERED BY DENTAL INSURANCE? Yes____ No____ DUAL INSURANCE? Yes____ No____

PRIMARY INSURANCE COMPANY:_____ SUBSCRIBER NAME:_____

INSURANCE I.D.:_____ SUBSCRIBER DATE OF BIRTH:_____ GROUP NO.:_____

SECONDARY INSURANCE COMPANY:_____ SUBSCRIBER NAME:_____

INSURANCE I.D.:_____ SUBSCRIBER DATE OF BIRTH:_____ GROUP NO.:_____

FINANCIAL POLICY:

Payment is due at the time of service unless other arrangements have been made. We accept Visa, MasterCard, Discover, American Express, check, cash and money orders. In addition, we are affiliated with Care Credit, a dental credit card for which you can apply in our office and have no-interest payments.

As a courtesy, we are happy to submit your insurance claim to your insurance company. Please provide us with the necessary information.

IF YOU HAVE INSURANCE:

- We are only able to estimate your financial responsibility.
- We are unable to guarantee payment or eligibility from your insurance company.
- Your portion is expected at the time services are rendered.

To the best of my knowledge the above information is correct and current. I/we, the undersigned, give consent to Dr. Brian P. Black/Desert Pearl Dentistry to secure x-rays and perform whatever diagnostic procedures are necessary for the determination of a treatment plan. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.**

Signature of Patient (Parent signs for minor):_____ Date:_____