PATIENT INFORMATION

(Circle One) Dr. Mr. Mrs. Ms. Maiden Name: ____________

Name: (last) ____________ (first) ____________ (middle) ____________

Complete Street Address: ____________

City, State, Zip Code: ____________

S.S.#: ____________ Date of Birth: ____________ E-Mail: ____________

Home Phone: ____________ Work Phone: ____________ Cell/Pager: ____________

How would you like us to contact you? ____________

Relationship to Responsible Party: ____________

Other children in the family: (please list names and ages) ____________

How did you learn of our Dental Practice? ____________

If over 18, are you a full time student? ____ Yes ____ No If yes, what school do you attend? ____________

RESPONSIBLE PARTY INFORMATION

(Circle One) Dr. Mr. Mrs. Ms. Maiden Name: ____________

Name: (last) ____________ (first) ____________ (middle) ____________

Complete Street Address: ____________

City, State, Zip Code: ____________

How long at this address? ____________

If less than 3 years, please list previous address: ____________

S.S.#: ____________ Date of Birth: ____________ E-Mail: ____________

Home Phone: ____________ Work Phone: ____________ Cell/Pager: ____________

How would you like us to contact you? ____________

Name of Employer: ____________ City: ____________

Occupation: ____________ # of years employed: ____________

Spouse's Name: ____________

Spouse's Employer: ____________ City: ____________

Occupation: ____________ # of years employed: ____________

INSURANCE INFORMATION

Policyholder's Name: ____________ S.S.# ____________ Date of Birth: ____________

Relationship to Patient: ____________

Insurance Company: ____________ Group #: ____________

Insurance Company Address: ____________

Name of Employer: ____________ City: ____________

DO YOU HAVE DUAL COVERAGE? Yes No If yes, please complete for 2nd Insurance Policy.

Policyholder's Name: ____________ S.S.# ____________ Date of Birth ____________

Relationship to Patient: ____________

Insurance Company: ____________ Group #: ____________

Insurance Company Address: ____________

Name of Employer: ____________ City: ____________

EMERGENCY INFORMATION

Name of nearest relative not living with you: ____________

Complete Street Address: ____________ City, State, Zip Code: ____________

Home Phone: ____________ Work Phone: ____________ Cell/Pager: ____________

I understand that, where appropriate, credit bureau checks may be obtained.

____

Signature (parent or guardian signature if minor) Date

FINANCIAL POLICY

Thank you for choosing Dr. W. Keith Appel as your dental provider. The following is a statement of our financial policy, which must be read and signed prior to any treatment.

INVESTMENT

The investment needed to complete your necessary dental treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as your treatment progresses, this estimate may have to be revised. You will be consulted before any additional treatment is undertaken. This estimate will be honored, provided treatment is completed within six (6) months of the date of this examination.

DENTAL SERVICES

FINANCIAL OPTIONS

1. Cash or Check (Circle One)
2. Credit Card: (Circle One) Visa MasterCard Discover
3. Medical Bureau of Pittsburgh – Interest Free Financing. Call 412-539-0990 for additional details.
4. Care Credit - Interest Free Financing Call 1-800-365-8295.

MISSED APPOINTMENTS

No charge will be made for the rescheduling of an appointment provided a 48 hour notice is given. Otherwise, a minimum charge of $25 per half-hour missed appointment fee may be incurred. Once an appointment has been made, please remember this time has been reserved especially for you.

INSURANCE ASSIGNMENTS

Your insurance policy is a contract between you and your insurance company. If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for the treatment rendered. The estimate provided by this office is considered as a guideline until the final insurance payment, if any, is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 61st day after treatment is rendered, the total outstanding account balance will be billed to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer any question you may have regarding our services.

COLLECTION FEES

Fees incurred to enforce payment required by this agreement, must be paid by the delinquent client whose failure to pay the required amount caused a collection fee to be incurred. Submission to treatment implies consent as outlined in this agreement.

CASH DISCOUNT

A discount of 5% will be offered to all patients paying by cash or check, provided all fees are paid in full at time of service and no other discounts or reduced fees are provided.

FINANCIAL CONSENT

The patient (guardian) agrees to be fully responsible for total payment of procedures performed in this office, including any treatment not considered as a benefit (non-covered services) of any dental insurance the patient may have. I have read this financial policy, understand my obligation and agree to comply with the above terms. I may request a copy of this policy after signing.

Signature of Patient or Responsible Party ______________________ Date ____________