



Patient Information

Today's Date: _____

Patient Name: _____ Preferred Name: _____
Last First MI

Male Female Married Single Child Other _____
Responsible Party for child: _____

May we contact you in regards to your account activity using the personal information below? Yes No

SS # Patient: _____ SS # Responsible Party: _____

Phone (Home): _____ (Work): _____ Emergency contact: _____ Cell: _____

Birth Date: _____ E-Mail Address: _____

Home Address: _____
Street City/State Zip Code

Employer Name: _____ Position: _____ How long there?: _____

Please list other members of your immediate family who are patients in our office that you would like to have linked with your account _____

Referral Information

Can we thank someone for referring you?

Family Member _____
Coworker _____
Friend _____
Doctor _____

Or did you find us on your own?

- Our Website
- Yellow Pages
- Lumineer or 6 Month Braces Referral
- Insurance Company
- Location
- Mail
- Other _____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? Yes No

Are you interested in sedation dentistry? Yes No

Why did you leave your previous dentist? _____

If you could change your smile and/or oral health, what would you do? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Straighter teeth | <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Fresher Breath |
| <input type="checkbox"/> Whiter Teeth | <input type="checkbox"/> Lower cavity risk | <input type="checkbox"/> Less Pain in Jaw |
| <input type="checkbox"/> Eat and Chew Better | <input type="checkbox"/> Get rid of ugly dark fillings | <input type="checkbox"/> Taste food better |
| <input type="checkbox"/> Stop snoring | <input type="checkbox"/> Better fitting denture | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Grinding/Clenching/Clicking | | |

Do you prefer to see a particular doctor in our practice? _____

INSURANCE INFORMATION

Primary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Secondary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Medical Insurance

Medical Insurance Company: _____ Policy Holder's Employer: _____

Policy Holder's Name: _____ Member ID#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

OPTION TO AUTHORIZE RELEASE OF INFORMATION TO FAMILY MEMBERS

Today's Date: ___ / ___ / ___ Patient Name: _____ DOB: ___ / ___ / ___

Many of our patients allow family members such as their spouse, parents, or others to call and request dental or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to the family members listed below.

I authorize Normandy Dentistry to release my dental and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Please list all authorized person(s) who will bring your child/children to their dental appointment. We require a six month medical update to be completed at your child's appointment, thus making the person bringing your child to the appointment responsible for any medical changes, current medications and dental concerns.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by the federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing

/_____
/_____
Date

Print Name of person completing forms

Signature of person completing forms

Financial Agreement

Thank you for selecting Normandy Lake Dentistry as your primary dental care provider. We are dedicated to ensuring your experience and dental care with us are both comfortable and exceptional. Below is an outline of our financial policy, which we require you to review and sign before your appointment with one of our providers.

Financial arrangements must be finalized prior to receiving treatment as a condition of your visit. Please understand that settling your bill is integral to your treatment process. Our practice relies on patient reimbursement to cover the costs incurred during your care, and financial responsibility on the part of each patient must be established before treatment commences. All patients are required to complete our Information and Insurance form before their appointment.

We accept payments in the form of cash, checks, Visa, Mastercard, American Express, Discover, Sunbit and Care Credit.

Insurance:

Your coverage is determined by your employer's selection, or if you have a self-purchased plan it is determined by your policyholder. Our office will collaborate with you to maximize the benefits available under your plan. However, most dental insurance plans do not cover the entirety of your treatment costs. Therefore, you are expected to pay your deductible and the estimated co-payment on the day services are rendered. As a courtesy for our patients, we will file your insurance claim on your behalf. Upon processing, you will receive an explanation of benefits 3-4 weeks before our billing department. Explanation of Benefits, which is not a bill but rather a description of the reimbursement from your insurance and any associated co-payments for covered benefits. The explanation of benefits does not reflect the balance on your account, any non-covered benefits will be added to the patient portion reflected on your explanation of benefits. Due to variations between insurance carriers (such as deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions), we cannot guarantee estimated charges. **As your insurance agreement is between you and the insurance company, you are ultimately responsible for all charges.** Rest assured, we will make every effort to ensure you receive the full benefits from your insurance company. If a claim is denied due to insufficient information, we will promptly submit an appeal with the requested details. **However, if the denial is due to invalid patient information and we do not receive a response from you within 60 days of service, the claim will be closed, and you will be responsible for the balance.**

Unpaid Insurance Claims:

If your insurance company has not settled its estimated portion within 60 days of the service date, you will receive a balance warning letter via email. After 90 days since your service date, you are required to pay the outstanding balance in full at that time. For insurance reimbursement, it will be your responsibility to fight with your insurance company for benefits covered by your dental plan. **Accounts with balances over 90 days since the first collections warning statement is sent will be referred to an attorney or collections agency.** If you are sent to collections a 35% fee will be added to your balance. Anyone aged 18 or above must sign our financial agreement before treatment. For individuals under 18, a legal guardian must sign all policy agreements. The signing guardian assumes responsibility for any outstanding balance, including amounts referred to collections.

Customary Rates:

Our practice is dedicated to providing top-tier treatment at customary rates for our area. **Regardless of any insurance company's fee determinations, you are responsible for payment of our in-office fees.** If you

have a lapse in coverage or are no longer subscribed to a dental benefit plan, we offer an in-house discount plan with affordable monthly payments. Please consult with our office manager for further details. **Please note you can not use our in-house discount plan in conjunction with dental insurance or any other dental discount plan.**

Unpaid Balances:

All unpaid balance statements will be sent to you electronically. Any unpaid balances after 60 days will receive a collection warning letter from our billing department to the address on your account. After the collections warning letter is sent to your household, you will have an additional 30 days to pay your balance in full or set up a payment plan with your office before the account is submitted to a collections agency.

Emergency Services:

In the event of an emergency procedure (i.e. root canal or oral surgery), you will be seen by one of our emergency services providers. **When being seen by an emergency services provider, you may be billed to the maximum allowance due to the provider being out-of-network with your benefit plan.**

Missed Appointments:

We kindly request a minimum of 48 hours notice for appointment cancellations or rescheduling. Your cooperation enables us to better serve you by optimizing our scheduling. **Failure to provide timely notification of a missed appointment will result in a \$50.00 missed appointment fee. After three missed appointment fees you will only be able to be seen in the office on a same-day basis.**

Scheduling:

When scheduling an appointment for any form of treatment, you will be required to pay **30%** of your out-of-pocket expense to reserve your time with the provider. If you need to cancel your appointment, the down payment can be refunded or used as a credit on your account. **If a treatment with a provider is canceled twice you will then be responsible for the full payment for treatment to reserve your time with the provider.**

Returned Check Fee:

In the event a check is returned for any reason, including insufficient funds, a \$35 check reprocessing fee will be applied to your account. This fee must be paid in addition to the original amount due.

Check Reprocessing Fee:

In the event that a check is not cashed within the allotted time and a check is needing to be reissued, a \$45 reissue fee will be deducted from the original check amount.

By signing below, I have read the above conditions of treatment and payment and agree to their content.

Signature: _____

Patient Name: _____

Date: _____