

Patient Information Sheet

Patient Name: _____ DOB: _____ M () F () SS# _____

Address: _____ City/State/Zip _____

Marital Status: _____

Home #: _____ Work #: _____ Cell: _____

Employer: _____ Shift: _____

Primary Dental Insurance: _____ Employer: _____

Policy Holder name: _____ Relationship to pt: _____

SS# _____ DOB: _____

Secondary Dental Insurance: _____ Employer: _____

Policy Holder name: _____ Relationship to pt: _____

SS# _____ DOB: _____

In case of an emergency please contact: Name: _____ Phone: _____

If Patient is a Minor:

Person responsible for acct/Guardian _____ Parent () Other ()

Address: _____ Phone: _____

Financial Policy

- We are considered **out of network** for **all insurance companies**.
- **Payment** is expected **at time of service**. This includes any copays or deductibles.
- For those with **Blue Cross Blue Shield** and **Delta Dental** **payment is due in full at the time of service**. We will **submit claims on your behalf**. If you have out of network benefits, you will receive this reimbursement directly from your insurance company.
- Care Credit is a 6-month interest free option if payment arrangements are needed. Find out more about Care Credit at carecredit.com.
- We **accept** Master Card, Visa, as well as HSA and FSA cards.
- It is **your responsibility** to know your dental coverage as this is a contract between you, your employer, and your insurance company.

This signature on file is my authorization for the release of any information needed to process my dental claims as well as my agreement to the above stated policies. I authorize my insurance benefits to be paid directly to Covarrubias Family Dentistry unless otherwise specified and understand that I am financially responsible for any balance not paid by my insurance company.

Signature: _____

Date: _____

- **Any missed appointments without 24hr notice may incur a fee up to the full amount of the visit but not less than \$75.00.**
- **2 missed appointments may lead to dismissal**