Patient Information Sheet

Patient Name: ______________________________ DOB: __________ M ( ) F ( ) SS#____________________

Address: ____________________________ City/State/Zip______________________________ Marital Status: _____

Home phone: _____________________ Work phone: ________________________ Cell: ________________________

Employer: ______________________________ Shift: ____________

Primary Dental Insurance: _________________________ Policy Holder name: ________________________________

Employer: _______________________________ Relationship to pt: _____________________

SS#____________________ DOB: _____________

Secondary Dental Insurance: ______________________ Policy Holder name: _________________________________

Employer: _______________________________ 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 recognize the need for a definite understanding of financial arrangements between patient and physician. In response to this need, we have established the following financial policy. If you have any questions regarding this policy, please do not hesitate to ask us.

- You are responsible for your deductible, co-payments, and/or any amount not covered by your insurance. We require payment for any of these out-of-pocket expenses at the time of service. If this is not possible, please make payment arrangements prior to treatment.
- We are Delta Dental Premier Providers. This means that we are considered out of network for all other insurance companies.
- We do our best to provide you with an accurate estimate of your co-pay, however, it is not guaranteed to be your final payment. It is your responsibility to know your dental coverage as this is a contract between you, your employer, and your insurance company. We are happy to submit insurance claims on your behalf regardless of network status. Any insurance benefit received helps reduce your out-of- pocket expense, however, we ultimately hold you responsible for the full charge of your care in our office regardless of insurance benefits.

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 be paid directly to Dr. Robert L. Houghtalng, Jr. and understand that I am financially responsible for any balance not paid by my insurance company.

Signature: __________________________________ Date:______________________