

# Linden Hills

## DENTISTRY

WELCOME TO OUR OFFICE.

PLEASE PRINT.

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
*Last* *First* *Middle*

Preferred Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex:  M  F

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Address: \_\_\_\_\_

*City*

*State*

*Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

If Child, Parents' Names: \_\_\_\_\_

If Student, School Name: \_\_\_\_\_

Family member who already has an account here: \_\_\_\_\_

How did you learn about our clinic? \_\_\_\_\_

**COMPLETE THE FOLLOWING ONLY IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR INCURRED CHARGES.**

Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

*City*

*State*

*Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

– OVER PLEASE –



## FINANCIAL INFORMATION

Our business staff “understands” insurance and will be glad to assist you in obtaining the maximum benefits specified in your contract. We will also file your dental claim with your insurance company for you.

You must realize, however, that...

1. Your insurance program is a contract between you, your employer and the insurance company. **We are not a party to that contract.**
2. Our dental treatment recommendations are based upon what the dentists feel is the best dental treatment for your optimal dental health. We do not base our treatment recommendations on what any insurance company may or may not pay for services.
3. **Our fees are not always covered in full by the maximum allowance determined by your insurance carrier and not all services are covered benefits in all contracts. If your insurance company does not pay, it is your responsibility to pay for these services.**
4. Minnesota law requires that insurance companies pay or deny the claim within 30 working days from the receipt of the claim. If they are unable to pay or deny the claim they must notify **the patient** within the 30 working days as to why. **If you do not receive notification of payment, denial or pending claim from your insurance company within the 30 days, please contact your insurance company.**
5. In order to keep you informed as to the status of your account, you will receive monthly statements from our office.
6. There will be a finance charge of 1.5% per month on account balances over 90 days.
7. Should our office find it necessary to place your account with an attorney for collection, all charges incurred in this process will be your responsibility.

Patient Name: \_\_\_\_\_

Policy Holder (Employee): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

SS# of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Group or Contract #: \_\_\_\_\_ ID #: \_\_\_\_\_ Benefits Phone #: \_\_\_\_\_

Patients Covered by this Policy: \_\_\_\_\_

I hereby authorize payment directly to the doctor of insurance benefits to which I am entitled. I also hereby authorize release of any information, including the diagnosis and records of treatments or examinations rendered, to my insurance company or companies. I have read and understand the above financial information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_