WELCOME TO OUR OFFICE

Today's Date: ___________________________

Patient Name: ____

Preferred Name: _________________________

Marital Status: ___________________________ Gender Identity: ___________________

Date of Birth: ____________________________ Social Security #: __________-_________-__________

Patient Address: ____

____
City State Zip

Home Phone: ________________________________ Cell Phone: _______________________________

Work Phone: ________________________________ Best form of Contact: ☐Home ☐Work ☐Cell ☐Email

Email Address: ____

Occupation: ______________________________ Employer: _____________________________________

If Child, Parent's 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 THE PATIENT IS RESPONSIBLE FOR INCURRED CHARGES

Responsible Party: ____

Relationship to Patient: ____

Address: ____

____
City State Zip

Home Phone: ________________________________ Work Phone: ______________________________

Date of Birth: ________________________________ Social Security #: ____________________________

Occupation: _________________________________ Employer: _________________________________

-OVER PLEASE TO COMPLETE **FINANCIAL INFORMATION**-

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 you dental claims with your insurance company on your behalf.

Please understand…

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 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 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 **.66%** per month on account balances over 60 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 Ph #: ___________________

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: ________________

4289 Sheridan Ave South, Minneapolis, Minnesota 55410
612.922.6164