Foothills Dental Associates

Welcome to our office! We will do our best to make your visits as convenient and pleasant as possible. If at any time, you have any questions about our treatment, appointment or fees, please let us know.

ACCOUNT HOLDER / GUARANTOR

Mr./Mrs./Ms. _____ Birthdate _____
Last Name First Name Middle Initial

Address _____ Social Security # _____
Number and Street

_____ Home Phone # (____) _____
City State Zip

Employer _____ Pager/Cell# (_____) _____

Position _____ Work Phone # (_____) _____ E-mail: _____

NAME OF SPOUSE, SECOND PARENT OR GUARDIAN

Mr./Mrs./Ms. _____ Birthdate _____
Last Name First Name Middle Initial

Address _____ Social Security # _____
Number and Street

_____ Home Phone # (____) _____
City State Zip

Employer _____ Pager/Cell# (_____) _____

Position _____ Work Phone # (_____) _____ E-mail: _____

ADDITIONAL FAMILY MEMBERS OR DEPENDANTS WHO MAY BECOME OUR PATIENTS:

Name	Relationship	Birthdate	Sex

EMERGENCY CONTACT: (Relative or friends not living with you)

Name _____ Home Phone # (_____) _____
Last Name First Name Middle Initial

Address _____ Work Phone # (_____) _____
Number and Street

_____ Relationship _____
City State Zip

Name _____ Home Phone # (_____) _____
Last Name First Name Middle Initial

Address _____ Work Phone # (_____) _____
Number and Street

_____ Relationship _____
City State Zip

We appreciate the confidence our patients have in us and would like to know **whom we may thank for referring you to our office.**

_____

If you did not have a personal referral, **how did you hear of our office?** _____

FOR OFFICE USE ONLY

DOCTOR	ACCOUNT NAME	ACCOUNT #	ACCOUNT TYPE	ACCOUNT SETUP : DATE/STAFF MEMBER

Foothills Dental Associates Office Guidelines

Thank you for taking the time to fill out this account information form. The following guidelines are intended to help meet the needs of all our patients.

When you make an appointment, that time and procedure is carefully planned to meet your individual needs. Please do not reschedule your appointment unless it is absolutely necessary, for it is often difficult to schedule someone else in a time that was reserved for you. If you are not able to keep an appointment, please give us as much notice as possible. If less than 24 hours is given, we reserve the right to charge you for the missed appointment time.

We are always happy to answer any questions you may have. You should be kept informed as to what treatment is needed and what it will cost. **(All fees are due at the time treatment is performed unless other arrangements have been approved in advance.)** All outstanding account balances over 60 days will bear a charge of 1 1/2% per month (18% per year) from the date the fees are charged until they are paid.

For your convenience, we will gladly file dental insurance claims for you. We will allow you to assign the insurance payment to our office provided we receive the following from you:

1) Copy of your insurance card and photo I.D.
2) The booklet or literature provided by your insurance company that tells what benefits you have.
3) Your signature on file that assigns benefits to our office.

It is our office policy to bill your insurance carrier as a benefit to you, although YOU are responsible for the entire balance. Once the carrier is billed, we will set aside that portion of the balance estimated to be paid by your insurance carrier for 60 days. **IF YOUR CARRIER DOES NOT REMIT PAYMENT WITHIN 60 DAYS, THE BALANCE WILL BE DUE FROM YOU. WHEN INSURANCE PAYMENT IS RECEIVED WE WILL REFUND THE CREDIT AMOUNT IF ANY, TO YOU.**

The undersigned has read and understands the above and hereby authorizes the Doctor to perform any procedure that is deemed necessary in the best interest of the patient's health.

_____ _____
Signature of Account Holder/Parent/Guardian Date

_____ _____
Signature of Spouse of Second Parent/Guardian Date

PRIMARY INSURANCE

Policy Holder _____ Birthdate _____ Social Security # _____

Employer _____ Policy #/Group # _____ Effective Date _____

Insurance Company Name _____ Insurance Co. Phone # _____

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I, the undersigned, have insurance with _____ and assign directly to Foothills Dental Associates all benefits,
Name of Insurance Company(ies)
if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured / Spouse of Insured Date

MINOR CHILD CONSENT

I, being the guardian of _____ do hereby request and authorize the dental staff to perform necessary
Name of Minor/Child
dental services for my child, including but not limited to x-rays, and administration of anesthetics which are advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Signature of Parent(s) / Guardian Date

FINANCIAL AGREEMENT I acknowledge that payment is due at the time of treatment, unless other arrangements are made in writing prior to treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child on my account. I accept full financial responsibility for all charges not covered by insurance. If account becomes delinquent, all collection expenses including agency fees and/or reasonable attorney fees will be borne by my account.

_____ _____
Signature of Account Holder(s) / Parent / Guardian Date

_____ _____
Signature of Account Holder(s) / Parent / Guardian Date