CHILD WELCOME FORM

PATIENT INFORMATION

Patient Full Name____

Birth date _______________SS# ________________________

FINANCIALLY RESPONSIBLE PERSON(S)

Full Name____

Relationship to Patient ___________________________________

Address____

City____________________State________Zip ______________

SS#_________________________ Birth ____________________

Phone (h) _____________________(m)____________________

Email Address ____

Employer _______________________Ph. (w)_______________

Spouse/Guardian Name ___________________________________

SS#_________________________ Birth ____________________

Employer _______________________Ph. (w)_______________

WHOM MAY WE THANK FOR REFERRING YOU?

❑ Friend, ❑ Relative, ❑ Physician, ❑ Dentist, ❑ Internet,
❑ Facebook, ❑ Google,
❑ Other ____

Their name ____

We want to get to know you. Tell us a little bit about yourself: family, job, favorite foods, favorite movies, favorite music, favorite things to do:

YOUR DENTAL HISTORY

Who was your previous dentist?

Name ____

City_________________________State______________________

Phone ____

Why did you leave your previous dentist?

CANCELLATION FEE POLICY

Please be advised there will be a cancellation fee charged for missed appointments or appointments rescheduled within **48 hours** of the original appointment time. The fee will be a minimum of $25 or may be assessed at 20% of the scheduled procedure rate.

I have been advised of Lord Family Dentistry's cancellation fee policy.

Patient Signature ____

TELL US ABOUT YOUR SMILE

If you could change your smile, would you:
(Please check all that apply)

❑ Make your teeth whiter
❑ Make your teeth straighter
❑ Close spaces between teeth
❑ Replace black metal fillings w/ tooth-colored restorations
❑ Repair chipped teeth
❑ Replace missing teeth
❑ Replace old crowns that don't match
❑ Have a smile makeover

For parents/guardians bringing children for treatment

We are so honored that you have entrusted your child's dental care with us. In our experience, when young children get acquainted with our staff and familiarize themselves with their surroundings, they have a much calmer and pleasant experience; this in turn invites a life of good dental care. We have also found when parents accompany their children in treatment rooms, kids are less apt to interact with us. For this reason, we've made if office policy that parents are not present in the treatment room. Feel welcome to walk your child back to their chair and/or have a tour of the office, but please allow us to get to know your child. We ask for your confidence in this decision and know we have your child's best interest in mind; and we will take the best possible care for them.

initial

What is the most important thing to you about your dental health?

What is the most important thing to you about your dental visit today?

DISCLAIMER

I understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the release of all identifiable information concerning my account, including charges billed, payments made, and interest charges assessed to Lord Family Dentistry and any agency this practice decides to use. I authorize the release of information to insurance carriers to collect on my behalf. I authorize payment to be made directly to Lord Family Dentistry.

Signature ____

Today's Date ____

LORD FAMILY cosmetic & restorative Dentistry

FOR DENTAL INSURED PATIENTS

initial <u>Insurance Coverage:</u>
Dental Insurance can be confusing and cannot be compared to Health Insurance. Our goal is to help maximize your dental benefits, but it is your responsibility to know your insurance. Please remember that the benefits available under the terms of your dental contract have been **determined by your employer** and your insurance carrier. We care for you **based on proper dental standards**, **not on an insurance company's benefit package.** This dental office treats patients with hundreds of different insurance plans and benefit structures. **We cannot accurately predict before or during treatment what will be paid (<u>if any</u>) on your claims,** therefore expect a statement after treatment.

initial <u>Why would I get a statement after treatment?</u>
Your ESTIMATED co-pay is due in full the day of treatment, and then we will bill your insurance. Once your claim has been processed and returned to our office, any remaining balance due to denied or partial coverage will be billed to you and expected to be paid promptly by you. We will credit all collections received to the designated account.

PRIMARY DENTAL INSURANCE:
Name of subscriber ____
Relation of subscriber to patient ____
Employer ____
Name of Insurance Company ____
Subscriber Birth date ______________________ SS# ______________________

PAYMENT ARRANGEMENTS FOR ALL PATIENTS

Lord Family Dentistry strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that you deserve. Our goal is to take good care of you and your family and to help you afford your dental choices. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, **financial responsibility on the part of each patient must be determined before treatment**.

At the onset of treatment, we will provide you with an **ESTIMATE** of the total fees expected. Please understand this will only be an estimate. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

Please take a moment to review the financial plans and **INITIAL** in the box, (do not check), your preferred form of payment.

initial <u>Plan A: Prepayment</u>
We are happy to accept prepayments for all treatment scheduled.

initial <u>Plan B: Payment as services is rendered</u>
You may use cash, check, credit or debit card to make payment at the time of service. We gladly accept MasterCard, Visa, Discover Card, and American Express.

initial <u>Plan C: Finance Options</u>
If you want to make monthly payments, we offer short and long-term financing through Care Credit or First Financial. **By checking this box, you will authorize one of our team members to obtain your credit report and assist you with the application process.**

In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the dentist, I agree to pay the reasonable value of services rendered to Lord Family Dentistry at the time services are rendered or within five (5) days of rendering said services. I understand that I am financially responsible for all charges whether paid by an insurance company. I understand that Lord Family Dentistry cannot render services on the assumption that charges will be paid in full by an insurance company. I agree that if payment cannot be made at time of service, treatment may be denied, and I am responsible for any damage incurred.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

I am aware if payment in full for charges incurred is not made within **<u>60 days</u>** of my treatment; I agree to pay all costs of collection including a **<u>40% collection fee</u>**, attorney costs, and court costs.

I understand that there will be a $25 charge on all returned checks. I understand after one check is returned, the only method of payment this office will accept is cash or credit.

I grant my permission for Lord Family Dentistry to contact me at home or at my place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering machine or with a family member.

This agreement supersedes all prior arrangements signed, including all mediation/arbitration agreements. I acknowledge that any prior agreements related to financial arrangements or quality of care are null and void. I hereby agree to abide by the condition outlined herein.

Patient Signature ______________________ Today's Date ______________