

NEW PATIENT ENROLLMENT FORM

We will need to gather some information in order to begin a new patient record. The information gathered below is strictly confidential and will be used for internal office use and insurance purposes only.

Today's Date: ___/___/___ Date of Birth: ___/___/___ Age: ___

Last Name: _____ First Name: _____ MI: _____

Please check: Male Female SSN: _____

Spouse Name: _____ Date of Birth: ___/___/___ SSN: _____

Mailing Address: _____

Street

City

Zip

Phone numbers: Home: _____ Work: _____ Cell: _____

Email address: _____

Patient's Employer: _____

Spouse's Employer: _____

Emergency Contact: _____ Phone number: _____

How did you hear about us? Please check all that apply:

Friend or Family Name: _____, Insurance company , Website , Google

Drive By/Sign , Yellow Book , Mailing , Newspaper Ad , Other : _____

If you have dental insurance, please provide all pertinent information to our front office personnel for verification. Remember, your dental insurance is a contract between your employer and the dental insurance company. It is ultimately your responsibility to know the details of your plan. We will always help you with any questions you may have.

ASSIGNMENT AND RELEASE OF BENEFITS

I, the undersigned certify that I (or my dependent) have insurance coverage through _____ and assign benefits directly to Astor Smile Dental PLLC for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Astor Smile Dental PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party

Relationship

Date

ASTOR SMILE DENTAL PLLC PRACTICE STANDARDS

Treatment

We pride ourselves in offering the highest quality of care possible. Our doctors do not allow insurance companies to dictate the course of a patient's treatment.

Appointments

We realize that our patient's time is valuable; therefore, we make every effort possible to minimize or eliminate the wait. We reserve time specifically for each patient and we will do everything in our power to get our patients in and out on time. We request the same courtesy from our patients.

If you find it impossible to keep an appointment, please call our office at least 48 hours in advance.

Multiple cancelled appointments or no show will not be rescheduled and patients will be placed on a strict last minute availability for any appointment.

Financial Responsibility

- Patient portion is always due on the day of service unless alternative financial arrangements have been made.
 - We offer many payment options to allow your treatment to be comfortable and affordable. Please ask us about our payment plans when scheduling treatment.
 - Payments extending beyond 30 days from the first billing will accrue interest at the rate of 1.5% per month on the unpaid balance (18% annual rate).
 - There is a \$25.00 charge for all returned checks (NSF).
 - In the event of default, I promise to pay legal interest on the indebtedness, collection costs and related legal fees.
 - We take pride in our knowledge and make every attempt to gain access to all dental plan information. The final balance owed is always dependent upon the benefit processed by your insurance.
- You are responsible for any amount not covered by your insurance.

PLEASE SIGN BELOW INDICATING YOUR ACCEPTANCE OF THE PRACTICE STANDARDS:

- I have read and I understand the Astor Smile Dental PLLC Practice Standards
- I acknowledge that, upon request, I will be provided with a copy of the HIPPA privacy practices,
- I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to anonymously use my photographs for in-office patient education.
 - I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before commencing treatment.

Signature of responsible party

Date