



Date (D/M/Y): \_\_\_\_\_ Referred by (how you heard about us): \_\_\_\_\_

General Dentist/Previous Dentist: \_\_\_\_\_ How long since your last visit? \_\_\_\_\_

Mr/Mrs/Miss/Ms Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Birthdate (D/M/Y): \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_

Telephone: (M) \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ Best Phone: M / H / W

Email: \_\_\_\_\_

**Primary insurance:** Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Company: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Deductible? Y/N

Basic %: \_\_\_\_\_ Major%: \_\_\_\_\_ Plan Max:\$ \_\_\_\_\_ Ortho% \_\_\_\_\_ (age limit?) Ortho Max: \$ \_\_\_\_\_

Fee guide used – current year? Policy Year: Calendar / Fiscal Yr (ie. July 1-June 30)

Frequencies: Recall exams: \_\_\_\_\_ (# per policy year) Complete exams: \_\_\_\_\_ Bitewing x-rays: \_\_\_\_\_

Panorex x-ray: \_\_\_\_\_ Scaling/Root planing limits: \_\_\_\_\_ (#per policy year/rolling 12 months)

Fluoride age limit: \_\_\_\_\_ Composite (white) fillings on molars: Y / N

**Secondary Insurance:** Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Company: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Deductible? Y/N

Basic %: \_\_\_\_\_ Major%: \_\_\_\_\_ Plan Max:\$ \_\_\_\_\_ Ortho% \_\_\_\_\_ (age limit?) Ortho Max: \$ \_\_\_\_\_

Fee guide – current year? Policy Year: Calendar/Fiscal Yr (ie. July 1-June 30)

Frequencies: Recall exams: \_\_\_\_\_ (# per policy year) Complete exams: \_\_\_\_\_ Bitewing x-rays: \_\_\_\_\_

Panorex x-ray: \_\_\_\_\_ Scaling/Root planing limits: \_\_\_\_\_ (#per policy year/rolling 12 months)

Fluoride age limit: \_\_\_\_\_ Composite (white) fillings on molars: Y / N

**PLEASE READ AND SIGN BELOW**

Your appointment time has been specifically reserved for you and represents a commitment by you to your treatment. **Cancellations of appointments with less than 2 business days’ notice are subject to a cancellation fee of \$100.00 per appointment.** We appreciate your assistance in giving us sufficient notice so that we are able to offer your appointment time to another patient.

Our office is happy to offer direct billing to your insurance plan on your behalf; however, there are sometimes balances remaining after payment that will be due to you. We will do our best to be as accurate as possible, but your insurance is an agreement between you, your employer and the insurance company, and we will not always inform us. Should you have any questions regarding your insurance plan, please contact your HR department for assistance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_