Patient Information Form

Patient Name: First_____ MI_____ Last _____

Nickname_____ Email Address _____

I would like to receive: ☐ Appointment Reminders via text ☐ Appointment Reminders via email

Address: Street _____ City _____ State_____ Zip_____

Phone: Home_____ Work _____ Mobile _____

Date of Birth _____ Drivers License # _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zipcode _____

Sex ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Would You be interested in Sedation Dentistry? ☐ Yes ☐ No

On a scale of 1-10, how nervous are you about coming to the dentist? (*Circle one)* 1 2 3 4 5 6 7 8 9 10

Is the patient a minor? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No Name of School _____

Primary Care Doctor: _____ Phone Number _____

Pharmacy _____ Phone Number _____

Dental Benefit Plan information

Primary Dental Plan Name_____ **Phone** _____

Address: Street _____ City _____ State _____Zipcode _____

Name of Insured _____**Date of Birth** _____ **ID Number** _____

Group Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name_____ **Phone** _____

Address: Street _____City _____State _____Zipcode _____

Name of Insured _____**Date of Birth** _____ **ID Number** _____

Group Number _____ **Patient Relationship to Insured** _____

Medical Plan Information

Plan Name _____ **Phone** _____

Address: Street _____City _____State _____Zipcode _____

Name of Insured _____**Date of Birth** _____ **ID Number** _____

Group Number _____ **Patient Relationship to Insured** _____

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) _____ ☐ Advertisement _____

☐ Local Dental Society ☐ Our Web site ☐ Other (Please specify) _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the first initial visit. We accept the following forms of payment: Visa, Mastercard, Discover, Cash, Check , & Carecredit Financing Credit Card.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We do our best to give you an accurate estimate, however it is not a guarentee of payment. The amount not covered by the dental benefit, is the responsibility of the patient.

Scheduling of Appointments: We reserve the doctor or hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice.

Authorizations: *The information i have given today is correct to the best of my knowledge. I authorize Coastal Dental Associates to perform any necessary dental services that i may need and have consented to during diagnosis and treatment.* **_____(Initial)**

I have read the above and agree to the financial and scheduling terms. **_____(Initial)**

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) **_____(Initial)**

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice **_____(Initial)**

Signature_____ Date _____