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COSMETIC+FAMILY

Patient Information

Date_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____Cell Phone (_____)_____

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer_____ Email Address_____

Health Information

Reason for Today's visit: _____

Have you ever had any of the following? Please circle those that apply:

Allergies	Excessive Bleeding	Liver Disease	Stroke
AIDS	Fainting	Mental Disorders	Tuberculosis
Anemia	Glaucoma	Nervous Disorders	Tumors
Arthritis	Hay Fever	Pregnancy	Venereal Disease
Artificial Joints	Head Injuries	Radiation Therapy	Codeine Allergy
Asthma	Heart Disease	Respiratory Issues	Penicillin Allergy
Blood Disease	Heart Murmur	Rheumatic Fever	Other:
Cancer	Hepatitis	Rheumatism	
Diabetes	Hypertension		

Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please explain: _____

Current Medications:_____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other (If self you do not have to complete)

Name:_____
Relationship to Patient:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____

SSN#_____

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Insurance Information

Name of Insured_____DOB_____Relationship to Patient_____

SSN#:_____Name of Employer:_____ Work Phone: (___)_____

Insurance Company_____ Grp #_____
ID#_____

Ins Co Address:_____
Ins Co. Phone:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____Work Phone: (___)_____

Insurance Company_____ Grp #_____
ID#_____
Ins Co Address:_____
Ins Co. Phone:_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the examination. I also understand that treatment plans are an estimate of what insurance will pay and remaining balances are the patient responsibility.

In consideration for the professional services rendered to me, or at my request, by Dr. Davis, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date _____

Signature of patient, parent, or guardian

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1771 Commons N Loop

Tuscaloosa, AL 35406

Phone 205-523-0446

Written Financial Policy/Non-Covered Services

Thank you for choosing Davisdental Dentistry. Our primary mission is to deliver the highest quality and most comprehensive dental care available. An important part of the mission is making the cost of optimal care manageable for our patients by several payment options.

Payment Options:

-Cash, Visa, MasterCard, Discover, American Express
-Payment Plans for Care Credit (some no interest, some extended plans with interest)

Payment is due at the time of service. In some instances, a retainer fee or down payment may be required prior to scheduling a lengthy appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

There may be certain services that are not covered by your insurance company.

There may be certain services performed in which your insurance will downgrade to a lower paid service. In these cases you will be expected to pay the difference in fee schedule or pay for the service in full. For example, most dental contracts will pay for an amalgam (silver) filling on the posterior teeth when a composite (tooth colored) is used. For example, on a crown, you may choose a higher end porcelain /gold restoration. Any fee from the lab above the PPO or insurance plan fee schedule will be your responsibility.

In addition, most elective cosmetic dental services are not covered by your dental benefit contract. You are expected to pay for these services in full. We only estimate what your insurance will pay and they always give a disclaimer when calling for information that benefits and payments are not guaranteed until a claim is received and processed.

I, the undersigned, accept the charges as a legal and law debt and agree to pay said fee, including any/all cost of collection (33.33%), attorney fees and /or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other state.

I, the undersigned, also give Davisdental of Tuscaloosa PC, its employees and or agents "express prior consent" to contact me at any or all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care. Financial responsibility for each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangement, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and assist in making collections from insurance companies, or any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

I understand that fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said service to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

A fee is charged for patients who miss or cancel without 24-hour notice. Patients will also be subject to dismissal from the practice after two missed or cancelled appointments without 24-hour notice. Initial _____

Davisdental of Tuscaloosa PC charges $35.00 for returned checks

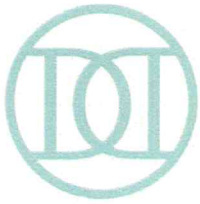
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Thank you for your understanding and we appreciate you choosing our office to assist you with your dental health.

I have read the above conditions of treatment and payment and agree to their content.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)



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1771 Commons North Loop

Tuscaloosa, AL 35406

Phone: 205-523-0446 Fax: 205-523-0449

admin@davisdentaloffices.com

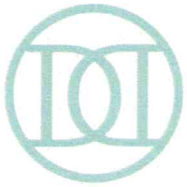
NOTICE TO ALL PATIENTS

We reserve appointment times to properly serve you and our other patients. If you are not able to keep your appointment, please contact us immediately. This early notice allows us the opportunity to serve you and our other patients promptly and courteously.

As of April 1, 2012, any missed appointments without 24-hour advance notice will be subject to a $25.00 charge to your account.

I have read and understand the above statement:

Patient Signature:_____



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Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)
