Patient Information

Name _____
Last

_____
First Middle

Address _____

_____
City State Zip

Phone (Home) _____(Cell) _____

E-mail _____

Birthdate_____

SS#_____

Sex ☐ M ☐ F

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor

☐ Separated ☐ Partnered for _____ years

Employer/School _____

Occupation _____

Spouse's Name _____
Spouse's Birthdate _____
Spouse's SS# _____

How did you hear about us?
Referred by patient (name) _____

Website_____ Other _____

Insurance Information

Primary Plan Member Information:

Name of Insured_____

Relationship to Patient_____

Insured's Date of Birth _____
Month/Day/Year

Insured's SS#_____

Insurance Co. Name _____

Member ID#_____

Is patient covered by additional insurance? ☐ Y ☐ N

Name of Insured_____

Relationship to Patient_____

Insured's Date of Birth _____
Month/Day/Year

Insured's SS#_____

Insurance Co. Name _____

Member ID#_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to James B. Lee, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

X_____
Responsible Party Signature

_____ _____
Relationship to Patient Date

Office Policies

Please place your initials by each to indicate that you have read and agreed to our policy.

_____ At least 24 hours advance notice is required for all appointment changes or cancellations. Otherwise, a $50 fee is charged for each appointment so affected.

_____ If you have questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations.

_____ Please be advised that the co-payment requested for services rendered is only an estimate of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is ***not a guarantee of payment,*** and the actual insurance benefit may differ from our estimates. ***The account holder is responsible for all charges the insurance company does not pay.***

_____ Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

X_____ _____
Responsible Party Signature Date