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) ______________________ ☐ Mailing ☐ Google Search

☐ Drive-By ☐ Our Web site ☐ Yelp ☐ Other (Please specify) ________________________

<u>Patient Responsibilities:</u> 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.

<u>Payment</u>: 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.

<u>Dental Benefit Plans</u>: 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.

<u>Scheduling of Appointments</u>: 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.

<u>Authorizations</u>: *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** ____________________