New Patient Information

frontdesk@thehillsfamilydentistry.com | 1231 Elfin Forest Rd West - Suite 112, San Marcos, CA 92078 | (760) 798-7166

Date: ________________

Patient Name: ______________ Last ______________ First ____ MI ______________ Preferred Name

Title: __________ Mr/Ms/Mrs/etc **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Parent complete form for child

Birth Date: __________ **Prev. Visit:** __________ **Email:** ______________________

Phone: __________ Mobile __________ Home/Land line __________ Work & Extension **Preferred Communication:** ☐ Text ☐ Phone Call

Address: ______________________ __________ City ______ State ______ Zip Code

Preferred Appointment Day:
☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri

Preferred Appointment Times:
☐ 8am - 12pm ☐ 12pm - 3pm ☐ After 3pm ☐ Any time

Whom may we thank for referring you to our practice? ☐ Google ☐ Yelp ☐ Name of person or office: ______________

Policyholder/Responsible Party Information

Does the patient have Dental Insurance? ○ Yes - Work Dental Insurance ○ Yes - Individual Dental Insurance ○ No Dental Insurance

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other ______________________

Name of Policyholder: (or Responsible Party) ______________ Last ______________ First ____ MI ______________ Preferred Name

Gender: ○ Male ○ Female **Birth Date:** __________ **Email:** ______________________

Phone: __________ Mobile __________ Home/Land line __________ Work & Extension

Preferred Time to Call:
☐ 8am-12pm ☐ 12pm-3pm ☐ After 3pm ☐ Any time

Policyholder's Address: (or Responsible Party) ______________________ __________ City ______ State ______ Zip Code

Employer's Address: ______________________ (Only complete if dental insurance is covered through work) __________ City ______ State ______ Zip Code

Employer's Phone: ______________________

Chart#: ______________
FOR OFFICE USE ONLY

Dental & Health Insurance Information

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Date: ____________

Patient's Name: ____________ (Last) ____________ (First) ____ (MI)

Patient's Birth Date: ____________

Patient's Address: ____________ ____________ (City) ____ (State) ____ (Zip Code)

Health Insurance

Does the patient have health insurance? ○ Yes - Work Health Insurance ○ Yes - Individual Health Insurance ○ No Health Insurance

Insurance Plan Name: ____________ **Patient's relationship to Policyholder:** ○ Self ○ Spouse ○ Child ○ Other

Name of Primary Policyholder: ____________ (Last) ____________ (First) ____ (MI)

Dental Insurance

Does the patient have dental insurance? ○ Yes - Work Dental Insurance ○ Yes - Individual Dental Insurance ○ No Dental Insurance

Patient's Relationship to Policyholder: ○ Self ○ Spouse ○ Child ○ Other: ____________

Insurance Plan Name: ____________ **ID #:** ____________ **Group #:** ____________

Insurance Address: ____________ ____________ (City) ____ (State) ____ (Zip Code)

Policyholder's Employer Name: ____________

Employer's Address: ____________ ____________ (City) ____ (State) ____ (Zip Code)

Additional Dental Insurance

Does the Patient have an additional Dental Insurance? ○ Yes ○ No (Skip the questions below)

Type of Dental Insurance: ○ Work Dental Insurance ○ Individual Dental Insurance

Patient's relationship to Policyholder: ○ Self ○ Spouse ○ Child ○ Other: ____________

Insurance Plan Name: ____________

Insurance Address: ____________ ____________ (City) ____ (State) ____ (Zip Code)

Policyholder's Employer Name: ____________

Employer's Address: ____________ ____________ (City) ____ (State) ____ (Zip Code)

Consent for Services

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As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payments payment is due. 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 grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other

Name: ______________________________

Signature: ______________________________ **Date** ____________