NEW PATIENT INFORMATION

Jonas Westbrook, DDS • Applewood Family Dentistry

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

How did you hear about us?

_____

ABOUT YOU

Name: _____ I prefer to be called:

_____

[ ] Male [ ] Female Birth date: _____ /_____ /_____ Age: _____

[ ] Single [ ] Married [ ] Child [ ] Other S.S. #: _____-_____-_____

Home Address:

_____

City/State/Zip_____ Home Phone: (_____)

_____ Work: (_____) _____ Cell: (_____)

_____

E-mail Address:

_____

_ Employer: _____

Employer's Address: _____

City/State/Zip: _____

In case of an emergency, please contact: _____ @

(_____)_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date:___/

___/___Relation: _____

Billing Address: _____

City/State/Zip_____ Home Phone: (_____)

_____ Work: (_____) _____

S.S. #: _____ Employer:

_____ Occupation:

_____ How long there?

_____ SPOUSE INFORMATION

Name: _____ Birth date:

____ /____ /____ Employer: _____ Work

Phone: (____) _____ ext. _____

Jonas Westbrook DDS • Applewood

Family Dentistry

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. Name: _____Phone: (_____)

_____ Insured's Name: _____ Insured's

Employer: _____ Insured's Social Security #:_____-_____-_____

Insured's Birth date:____ /____ /____Relation: _____ Insurance Co. Address:

_____

Subscriber ID #: _____ Group #:

_____

SECONDARY INSURANCE

Insurance Co. Name: _____Phone: (_____)

_____ Insured's Name: _____ Insured's

Employer: _____ Insured's Social Security #:_____-_____-_____

Insured's Birth date:____ /____ /____Relation: _____ Insurance Co. Address:

_____

Subscriber ID #: _____ Group #:

_____

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Westbrook. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Westbrook to release any information regarding my dental/medical history, diagnosis or treatment to third party payees and/or other health professionals.

Photography Release

I authorize Dr. Westbrook to take photographs of me to help me better understand my current dental condition and possible treatment options.

I understand and agree to the **General Consent to Treatment**. I authorize the **Release of Information**. I authorize **Photographs** to be taken of me to be used for my possible treatment options.

X _____ Date

_____

Signature of patient or parent /guardian

APPOINTMENT & FINANCIAL POLICIES

Unless another financial option is PRE-ARRANGED, **PAYMENT IN FULL IS DUE THE DAY OF THE TREATMENT**, or on pre-op visits for sedation appointments. Should a patient have dental

insurance with assignment to Dr. Westbrook, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

If you have dental insurance – understand that we file your primary insurance as a courtesy for our patients. We will also file your secondary insurance claim once the primary insurance has paid. If we do not receive payment from your secondary insurance policy within 30 days of filing, you will be responsible for the balance on your account. We do not have a contract with your insurance policy, only you do. Most plans only pay between 50-80% of the average dental fee. The percentage is usually paid determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. Insurance companies set their own fee schedules and each company uses a different set of fees. Insurance companies' allowable schedules are set arbitrarily and will never be at 100% of a clinic's fee. We have no control on how your insurance pays its claims or the amount they pay. We can only aid you in estimating your portion of the treatment cost; we at no time guarantee what your insurance will or will not cover with each claim.

If you do not have dental insurance, full payment is required at the time of service.

If we have knowledge that your insurance company sends payments to you rather than our dental office, you will be required to pay for the entire treatment at the time of service.

If your insurance company has not paid your account within 60 days, you are responsible for the balance on your account.

We accept payment in the form of Cash, Check, Visa, MasterCard, Discover Cherry Finance and Care Credit – Please ask our Office Manager about interest free financing.

A $35.00 fee will be applied for all NSF/returned/stopped payment checks.

If your account is referred to a collection agency, you will be responsible for all fees incurred.

Please make every effort not to change your scheduled appointment. If you must change an appointment, we require **2 WORKING DAYS ADVANCED NOTIFICATION** with our working days being **MONDAY THROUGH THURSDAY** so that we may use our time to accommodate other patients. **A charge of $50.00 will be applied for broken or missed appointments unless the TWO WORKING DAYS notice is given to our office**.

YOU WILL BE RESPONSIBLE FOR YOUR ESTIMATED FEES AND DEDUCTIBLE AT THE TIME OF SERVICE, AS WELL AS ANY BALANCE THAT MAY REMAIN AFTER YOUR INSURANCE PAYMENTS ARE RECEIVED.

I understand and will comply with our office Appointment & Financial Policy. I authorize and request my insurance company to pay my benefits directly to Dr. Westbrook.

X _____ Date _____

Signature of patient or parent /guardian