Detionals No.		PATIENT MEDIC	CAL HISTOR	RY	
Patient's Name:					For Office Use Only
Address:					ID:
Audress:			Today's Date:	Date of Last Vis	it: Date of Med. History
City State Zip:			Email:		
Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.	: Marital Status:
Primary Dental G	Ingentou				
To the total design	atantor.		Home Phone:	Work Phone:	Cell Phone:
Secondary Dental	Guarantor:		Home Phone:	Work Phone:	Cell Phone:
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Physician Name:			Physician Phon	6:	
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For Office Use O Medical Alerts:	nly				
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Y N	Are you taking Birth Contr	ol Pills?	Y N	u smoke or use tobacco	Height: Weight:
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Medications:						
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Signature:			Date:			

(If Under 18, Parent or Guardian Signature Required)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I HAV	READ AND/OR RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES
PRINT	PATIENT NAME
SIGNA	TURE OF PATIENT OR LEGAL GUARDIAN
DATE	
	FOR OFFICE USE ONLY
	empted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, knowledgment could not be obtained because:
0	Individual refused to sign
0	Communication barrier prohibited obtaining
0	An emergency situation prevented obtaining
0	Other (please specify):

DR. DANA WEINREICH & ASSOCIATES FAMILY DENTISTRY FINANCIAL AND CANCELLATION POLICY

As a courtesy to our patients, we are happy to submit your dental claims to your insurance carrier. In addition, we will wait up to six (6) weeks for your carrier to pay your <u>estimated</u> claim amount. All insurance claims filed are required to be paid in full within sixty (60) days of the date of service **regardless** of whether your carrier has paid your dental claim. This means as a patient of record, you are ultimately responsible to pay your balance in full **IF** the practice has received payment from your insurance carrier within 60 days of the date of service. Many dentists do not offer this courtesy the patient must normally pay in full in advance and wait for reimbursement from their insurance carrier.

Insurance is designed to offset the cost of your dental care. It does not (in most cases) pay the full cost of services rendered. We <u>do</u> collect your **estimated** patient portion on the day that the service(s) is performed. We try as best as possible to estimate what your insurance will cover on your submitted claim; **however**, it is only an estimate. Patient portions cannot be fully determined until the claim has been processed and paid in full by your insurance carrier. Therefore, should there be a discrepancy between the estimated amount figured by this office and what has actually been paid by your insurance carrier, the remaining unpaid portion will be due from the patient within **10 days** of the practice receiving the insurance payment. We do issue statements both via email and USPS if there is additional money owed on the day that your insurance check is posted to your account. Whether or not you have received your email or mailed statement, the patient is responsible for their balance.

Dental insurance is a contract between the patient, patient's employer, and the insurance carrier and all charges are ultimately the patient's responsibility.

Patients without dental insurance agree to full responsibility of the total payment of all procedures performed at this office. Those procedures are to be paid in full at the time the services(s) are rendered.

Additionally, we reserve the right to charge a \$50 fee for appointments missed (no-showed) or cancelled without 24-hour notice.

Print Patient Name:	
Signature of Patient or Responsible Party:	
Date:	

Dental Insurance Information

Patient Name:	Date of Birth:
Subscribers Name:	Date of Birth:
Subscribers ID/Social Security #	
Primary Insurance Co:	
Group #	Effective Date:
Ins. Co. Address:	
Ins. Co. Phone #	Insured's Employer
Do You Have Dual Coverage? Yes o	or No (If yes complete below)
Insureds Name:	Date of Birth:
Insured's ID/Social Security #	¥
	Effective Date:
Ins. Co. Address:	
Ins. Co Phone #	Insured's Employer
As a courtesy, claims r	may be filed on my behalf
Signature:	Date: