

Date: _____

	Last	First	М	(preferred name)	
Gender M/F	Marital S	tatus: Married	I □ Single □	Divorced \square W	idowed
Date of Birth: Social		Security #:	E-Ma	il Address:	
Address:	Street				
				Apartment #	
	City	State		ZIP	
Phone #'s: Home _		Work	Ext_	Cell	
Primary Incuran		DENT	AL INSURAN		ry Incurance
Primary Insuran			lnour		ry Insurance
Insurance Co. Name					
Address:			_ Addr	ess:	
Phone #: Group #:	ID#		_ PIIOI	ie #	ID#
Group #:	ID#		_ Grou	ıp #:	ID#
Insured's Name: Insured's DOB	, , , , , ,		_ insur	ed's Name:	_/SS#
you currently taking Co	umadin (warfarin)	9 [1 Ves [1 No			
-			Are you taking Pl	avix or aspirin? []	Yes [] No
you currently taking Core you ever had bacterial MEN: Are you pregnant	endocarditis?[]X	Ves [] No If Yes, Ap Nursing? [] Ye	Are you taking Ploproximate date(s)	avix or aspirin? []	Yes [] No
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Consent and Policy

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company listed in these forms to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions:

For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows;

- We are a contracted provider of Guardian Dental, and Cigna "DPPO plan ONLY" (note that if your plan states anywhere on your card "advantage" they may pay less). Any other PPO or Indemnity insurance will be considered "Out of Network" and will require payment in "Full" at the time of service. We will be happy to submit the claims on your behalf for reimbursement.
- The contractual agreement for your dental benefits is between you and the insurance company. We provide billing as a courtesy.
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any or all co-pays, deductibles, or co-insurance amounts due in accordance with the explanation of benefits.
- When insurance benefits have been exhausted and/or terminated, you are responsible for any charges incurred.
- In all cases, you will be responsible for non-covered services that are not covered by your dental plan.
- We are limited to the information that is given to us by your insurance company and cannot be held responsible for percentages or benefits estimated.
- However, it is your responsibility to know your dental plan coverage.

Payment Agreement:

- Payment is due when services are rendered. Accounts may be assessed a late charge of 1 ½% per month, not to exceed 18% annual interest. If any account is sent to collections a collection fee will be added to your account.
- Should your account be placed in collections, you will be responsible for any and all fees and court costs incurred.

I authorize the doctors of Davis Dentistry and office to release all information necessary to secure the payment of benefits. I have read and agree to be financially responsible for all services performed by Dr. Mark Davis and staff.

Printed Name	
	_
Signature	Date