DEXTER DENTAL STUDIO

Healthy Mouth. Healthy Body. Healthy Mind.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

Patient Information

Name: _____Preferred Name: _____
DOB: _____SS#:_____Driver's License : _____
Address: _____
Home Phone: _____Work Phone: _____Cell Phone: _____
Email: _____ □Email to send appointment reminders □Text to send appointment reminders

Marital Status: ☐Single ☐Married ☐Divorced/Separated ☐Widowed **Sex Assigned at birth:** ☐Male ☐Female

Responsible Party (*IF* someone other than the patient)

□Responsible Party is also a Policy Holder for Patient □Primary Insurance Policy Holder □Secondary Insurance Policy Holder
Name: _____Preferred Name: _____
DOB: _____SS#:_____Driver's License: _____
Address:_____
Home Phone: _____Work Phone: _____Cell Phone: _____
Email: _____ □ Email to send appointment reminders □Text to send appointment reminders

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other_____
Insured DOB: _____ Insured SS#:_____
Employer Name and Address: _____Phone#:_____
Insurance Company Name and Address: _____
Insurance Company Phone #: _____
Insurance ID#:_____Insurance Group#: _____

Secondary Insurance Information

Name of Insured: _____Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other_____
Insured DOB: _____Insured SS#: _____
Employer Name and Address: _____Phone#:_____
Insurance Company Name and Address: _____
Insurance Company Phone #:_____
Insurance ID#:_____Insurance Group#:_____

HIPAA-Acknowledgement of Receipt

I acknowledge that I have read a copy of the Notice of Privacy Practices for Dexter Dental Studio, PLC

Patient/Guardian Name (Print): _____

Patient/Guardian Signature: _____Date: _____

Dexter Dental Studio Patient Disbursement Contract

We are here to build health-enhancing relationships and friendships with the people in our reach. We each bring a strong personal commitment to our work and make a significant difference in the lives of others.

To help you achieve the health you deserve, we want you to experience our quality of care. Together, we will help you learn how you can afford the dentistry you desire. We accept a variety of payment methods to assist you with our financial responsibility for your dental treatment. These include cash, checks, and major credit cards. Additionally, we offer a financial partnership with Care Credit.

In that light, our practice is not an insurance-driven practice. As a courtesy to you, we will do our very best to maximize your dental benefits. We will process all your insurance claims, receive and post credit from your insurance coverage to your account. You should be aware that better insurance plans will pay towards a wider variety of services, while less expensive plans pay towards the least expensive treatment. All policies have limitations and do not cover 100% of the fees charged. Ultimately, it is your responsibility for the total cost of treatment regardless of what insurance reimburses.

We will gladly assist you with understanding your dental coverage at any time. We will help you obtain as much information as possible in order to assist you with understanding your reimbursement. If at any time you are dissatisfied with your dental reimbursement, you may want to discuss it with your Human Resources Department at your place of employment.

I understand that I am responsible for all the costs of my dental treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment or examination record rendered, to my insurance company. I understand that I am responsible for payment of services rendered, as well as any copayments and deductibles that my insurance does not cover. I hereby authorize payment directly to Dexter Dental Studio of the group insurance benefits otherwise payable to me.

Patient/Guardian Name (Print): _____

Patient/Guardian Signature: _____Date: _____