DENTAL SPECIALISTS
OF MILWAUKEE

Patient Information

Title (Mr. Mrs. Ms. Dr. Rev.)

Patient's Name_____Date of Birth_____

Address_____
Street City Zip Code

Phone No._____ Marital Status: Single Married Widowed Divorced

Patient's Social Security No._____Email Address_____

Patient's Place of Employment_____Phone No._____

Employer's Address_____

Spouse's or Parent's Name_____

Spouse's or Parent's Social Security No._____

Spouse's Place of Employment_____Phone No._____

Spouse's Employer's Address_____

Student: □ Full time □ Part time School_____City & State_____

Emergency Contact_____Phone No._____

General Dentist_____

Other Consulting Drs._____
(Ex: Physicians, Orthodontist, Endodontists, etc.)

Insurance Information

Name of Primary Dental Insurance_____Insured Name & Birthdate_____

Name of Primary Health Insurance_____Insured Name & Birthdate_____

Name of Secondary Dental Insurance_____Insured Name & Birthdate_____

Name of Secondary Health Insurance_____Insured Name & Birthdate_____

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Financial Agreement

Everyone benefits when office and financial policy agreements are understood. The following is a statement of our financial agreement, which we require you to read and sign.

Regarding Payment

Payment of the *estimated* patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, American Express
   - Checks that are returned to our office from your financial institution are subject to a $30 returned check fee.
2) Flexible payment plans of 6-12 months upon approval with Care Credit® Approval must be received prior to treatment date.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor.

Regarding Insurance

As a courtesy to you, we will gladly process your insurance claim forms. Dental insurance plans do not correspond to individual patient needs – all of our doctors will diagnose treatment based on your dental needs and not your insurance coverage. **Please note that our office is *in network* with Delta Dental Insurance only**.

Your insurance is a contract between you, your employer, and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of service. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. It is then your responsibility to pursue payment from your insurance company.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

You are financially responsible for all charges incurred, regardless of insurance coverage. Payment is due within 30 days of service being rendered. A 1% per month (12% per year) late payment fee will be assessed on any unpaid balance remaining after 30 days. If it is necessary to turn your account over to a collection agency, you will be charged a collection fee of 35% of the overdue balance.

Regarding Appointments – Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment, so we ask that you kindly give us a minimum of 2 business days notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If you cancel a surgical appointment within 2 business days of the appointment, we kindly ask for half down when rescheduling. If 3 or more appointments are broken in a 12-month period without 2 business days notice, a cancellation fee of $50 will be applied to your account.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the above and agree to my financial responsibilities as outlined. It is understood that this executed copy of the financial agreement shall also cover your dependent children if they are also patients of the practice.

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Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____