Hyline Dental
EXCELLENCE IN DENTISTRY

PATIENT — PLEASE FILL OUT FORM COMPLETELY

PATIENT LAST NAME	FIRST	MIDDLE	PREFERRED NAME	TODAY'S DATE	□ MALE □ FEMALE
DATE OF BIRTH	SOCIAL SECURITY NUMBER		MARITAL STATUS □Single □Married □Widow □Divorced □Separated		
MAILING ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE		EMAIL		

WE WILL CONFIRM YOUR APPOINTMENT ELECTRONICALLY THROUGH TEXT AND EMAIL
PLEASE LET US KNOW IF YOU WOULD LIKE NOT TO RECEIVE ELECTRONIC REMINDERS

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	RELATIONSHIP
EMERGENCY CONTACT	EMERGENCY CONTACT NUMBER

RESPONSIBLE PARTY OR PARENT — □ SELF

PERSON RESPONSIBLE LAST NAME	FIRST	MIDDLE	RELATIONSHIP
HOME PHONE □SAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
HOME ADDRESS □SAME AS ABOVE	CITY	STATE	ZIP CODE

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT □YES □NO	SCHOOL ATTENDING	CITY	GRADE

PRIMARY DENTAL INSURANCE — □NONE

INSURANCE COMPANY NAME	EMPLOYER	
SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE
ADDRESS (If different from patient)		
POLICY OR SOC. SEC. NO.	GROUP NO.	RELATIONSHIP OF PATIENT TO SUBSCRIBER □SELF □SPOUSE □CHILD □OTHER

SECONDARY DENTAL INSURANCE — □NONE

INSURANCE COMPANY NAME	EMPLOYER	
SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE
POLICY OR SOC. SEC. NO.	GROUP NO.	RELATIONSHIP OF PATIENT TO SUBSCRIBER □SELF □SPOUSE □CHILD □OTHER

PRIMARY CARE PROVIDER	PHONE NUMBER

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I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I understand that any radiographs and photos and study models taken will be strictly used for my care. This includes sending images to outside offices that are directly related to my care. (e.g.: Insurance companies, prosthetic laboratory, specialty referrals)

3. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

4. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

5. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

6. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

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Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:
1. Cash
2. Check
3. MasterCard
4. Visa
5. Discover
6. Care Credit (Interest may apply)

THERE IS A 3.5% PROCESSING FEE FOR ALL CREDIT/DEBIT CARD PAYMENTS

Patient with insurance: The **PATIENT** is responsible for the **ESTIMATED** non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make **PRIOR** arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 24 HOURS IN ADVANCE**.

AFTER 3 FAILED APPOINTMENTS, WE MAY DISMISS YOU FROM OUR PRACTICE.

I, _____, agree to these financial terms.
(Patient or parent/legal guardian)

Signature _____ Date_____