ADVANCED
DENTAL
PROSTHETICS

KENT J.HOWELL DMD, MS
PROSTHODONTIST

PATIENT INFORMATION FORM

NAME ______________________________ DATE ______________

PHONE (H) ______________ PHONE (W) ______________ PHONE (M) ______________

ADDRESS ______________________________ CITY __________ ZIPCODE __________

EMAIL ______________________________

BIRTHDATE ______________ MARITAL STATUS ______________ SSN ______________

EMPLOYER ______________________________ OCCUPATION ______________

WK ADDRESS ______________________________ CITY __________ ZIPCODE __________

SPOUSE'S EMPLOYER ______________________________ OCCUPATION ______________

SPOUSE'S WK ADDRESS ______________________________ CITY ZIPCODE __________

DENTIST ______________________________ YEARS AT THAT OFFICE ______________

EMERGENCY CONTACT & PHONE NO. ______________________________

RESPONSIBLE PARTY ______________________________

IF REFERRED, WHO MAY WE THANK? ______________________________

PATIENTS WITH DENTAL INSURANCE

INSURED PERSON ______________________________ SSN ______________

NAME OF PLAN ______________________________ PLAN # ______________

SPOUSE HAVE DENTAL INSURANCE? __________

SPOUSE SSN ______________ SPOUSE DOB ______________

NAME OF DENTAL PLAN ______________________________ PLAN # ______________

It is our policy that billing procedures be clearly understood prior to the onset of treatment. Payment is expected at the time of treatment. Payment may be made by cash, personal check or credit card. Extended payments may be available through prior financial arrangements with our office manager. Any balance reflected in your statement is due within 10 days of receipt of your statement. Monthly bookeeping fees may be applied to unpaid balances.

If you have dental insurance we will bill your primary insurance company, as a courtesy to you. Complete insurance information must be provided at the time of your first visit. All deductibles and copayments are due at the time of treatment. Please note that dental insurance is designed to help pay part of the cost of treatment. Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated and we cannot guarantee payment of your claims. We will be glad to assist you in filing for these benefits, but you are ultimately the one who is financially responsible for your treatment.

I have had the opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

In the event that it becomes necessary to place an account in collections, the patient is responsible for any additional legal and collection related costs that may be incurred. By signing below you indicate that you have read the preceding and understand that prosthodontic services are rendered in accordance with these terms.

I acknowledge I have reviewed a copy of this office's Notice of Privacy Practices.

SIGNATURE ______________________________ DATE ______________