PRESTON DENTAL CENTER

Dr. Gregory Mayes
Dr. Lisa Mayes
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NEW PATIENT ENROLLMENT FORM

Today's Date: *MM* _____ *DD* _____ *YYYY* _____

We will need to gather some information in order to begin a new patient record. The information gathered below is strictly confidential and will be used for internal office use and insurance purposes only.

Name: *First* _____ *Middle* _____ *Last* _____

Date of birth: *MM* _____ *DD* _____ *YYYY* _____ **Social Security Number:** _____

Age: _____ **Sex:** M F **Spouse Name:** *First* _____ *Last* _____

Spouse Date of birth: *MM* _____ *DD* _____ *YYYY* _____ **Spouse Social Security Number:** _____

Address: *Street* _____ *City* _____ *State* _____ *Zip* _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Please check this box if you would allow us to send appointment reminders via **text message** in the future.

Please check this box if you would allow us to send appointment reminders and messages about your dental care via **email**. We assure your confidentiality and your address will remain secure within our practice and not be shared with any third party.

Email: _____

Patient's Employer: _____ **Spouse's Employer:** _____

Emergency Contact: _____ **Phone Number:** _____

How did you hear about us? Please check all that apply:

Friend or Family Name: _____ Insurance Company Google Website

Drive By/Sign Yellow Book Mailing Newspaper Ad Other _____

If you have dental insurance, we will need a copy of your current dental insurance card, in order to file your insurance. Preston Dental Center files to all dental plans and will help maximize your benefits.

Remember, your dental insurance is a contract between your employer and the dental insurance company. It is ultimately your responsibility to know the details of your plan. We will always help you with any questions you may have.

ASSIGNMENT AND RELEASE OF BENEFITS

I, the undersigned certify that I (or my dependent) have insurance coverage through _____ and assign benefits directly to Preston Dental Center for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Preston Dental Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

INSURANCE INFORMATION

Social/Subscriber ID: _____ **Insurance Phone:** _____

PAYMENT INFORMATION

Number: _____ **Exp. Date:** *MM* _____ *YYYY* _____ **Security Code:** _____

PLEASE TURN THE PAGE, READ AND COMPLETE THE OTHER SIDE

PRACTICE STANDARDS

TREATMENT

We pride our selves in offering the highest quality of care possible. Our doctors do not allow insurance companies to dictate the course of a patient's treatment. We are a full service mercury free practice, we do not place any silver amalgam fillings but rather only place composite "white" fillings or porcelain restorations.

APPOINTMENTS

We realize that our patient's time is valuable; therefore, we make every effort possible to minimize or eliminate the wait. We reserve time specifically for each patient and we will do everything in our power to get our patients in and out on time. We request the same courtesy from our patients.

If you find it impossible to keep an appointment, please call our office at least 48 hours in advance.

Appointments not canceled within 24 hours and multiple canceled or no show appointments will be, at our discretion, charged a $50.00 fee. Also, multiple canceled appointments will not be rescheduled and patients will be placed on a strict last minute availability for any appointment.

FINANCIAL RESPONSIBILITY

- Patient portion is always due on the day of service unless alternative financial arrangements have been made.
- We offer many payment options to allow your treatment to be comfortable and affordable. Please ask us about our payment plans when scheduling treatment.
- Payments extending beyond 30 days from the first billing will accrue interest at the rate of 1.5% per month on the unpaid balance (18% annual rate).
- There is a $25.00 charge for all returned checks (NSF).
- In the event of default, I promise to pay legal interest on the indebtedness, collection costs and related legal fees.
- We take pride in our knowledge and make every attempt to gain access to all dental plan information. The final balance owed is always dependent upon the benefit processed by your insurance. You are responsible for any amount not covered by your insurance.

PLEASE SIGN BELOW INDICATING YOUR ACCEPTANCE OF THE PRACTICE STANDARDS:

- I have read and I understand the Preston Dental Center Practice Standards,
- I acknowledge that, upon request, I will be provided with a copy of the HIPPA privacy practices.
- I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to anonymously use my photographs for in-office patient education.
- I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before commencing treatment.

Signature of Responsible Party: _____

Date: *MM* _____ *DD* _____ *YYYY* _____