JEFFERY A. SPILMAN, D.D.S.

Thank you for choosing our practice and welcome.
If you have any questions or concerns, please ask for assistance. We are happy to help!

PATIENT INFORMATION:

Name:_____
Last name First name Initial Marital Status
Address:_____City:_____State:_____Zip: _____

Home phone:_____Work phone:_____Mobile:_____Email: _____

Sex: _____ Date of Birth: _____ Driver's License:_____SSN# _____

Employer:_____In case of emergency who should be notified? _____

How did you hear about us? _____

Dental Insurance & Responsible Party Information:

Person responsible for the account:_____Address:_____

Home phone:_____Work phone:_____Mobile:_____Email: _____

Insured's Name:_____Social Security #:_____Date of Birth: _____

Insured's Employer:_____Employer's address: _____

Insurance Co. Name:_____Insurance Co. address: _____

Insurance Co. phone:_____Relationship to patient:_____Group #: _____

I certify that I am covered by the aforementioned insurance company and I assign directly to Jeffery A. Spilman, D.D.S. all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered at the time of service and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize Jeffery A. Spilman, D.D.S. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I affirm the information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status and/or insurance status. I authorize the dental staff to perform the necessary dental services I may need.

Patient Signature:_____Date: _____

Financial Policy

We are committed to providing you with quality dental care. A clear understanding of your financial responsibility is important to our professional relationship.

FULL PAYMENT is due at the time of service. For your convenience we accept cash, check, and debit cards, MasterCard, Visa, American Express, Discover, and Care Credit. A fee of $50.00 will be charged for returned checks.

We are pleased that you have dental insurance coverage and we will be happy to assist you in using your benefit program. Our office staff understands your insurance coverage and will help you maximize the benefits allowed under your plan. You must realize however, that

- **Your** dental benefits are under a contract between **you, your employer**, and the insurance company. We are **not** a party to that contract
- Our fees generally are **not** fully covered by the maximum allowance determined by your carrier and all dental services may **not** be covered by your carrier, some procedures receive no benefits.
- **You** are responsible for all fees incurred for services rendered to you.

IF YOUR INSURANCE COMPANY HAS NOT PAID FOR YOUR ACCOUNT WITHIN 45 DAYS, THE BALANCE WILL AUTOMATICALLY BE BILLED TO YOU

Cancellation and No Show Policy: Since we reserve time for you we kindly request at least 48 hours notice when cancelling or rescheduling an appointment. Failure to contact our office within 24 hours of your appointment may result in a minimum $25 charge No shows, oversight, or disregard to our time reserved for you may result in a $35 charge.

Patient Signature:_____Date:_____ _____