CompleteDentalHealth
YOUR SMILE IS OUR REWARD
619.295.2202 • www.completedentalhealth.com

Timothy N. Collins, D.D.S.

PATIENT INFORMATION

Name (Mr., Mrs., Ms. Dr.) _____
Last First Middle

Residence/Address _____ City _____ Zip _____

Business/Address _____ City _____ Zip _____

Home Phone # _____ Business Phone # _____

Cell Phone # _____ E-mail Address _____

Date of Birth ____/____/____ Social Security # _____

If patient is a minor, Name of mother and father _____

Place of Employment _____

Occupation/Former Occupation _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____

Employer _____ Occupation _____

IN CASE OF EMERGENCY

Person To Contact _____ Phone # _____

Friend/Relative Not Living with Patient _____ Phone # _____

REFERRAL SOURCE

Whom may we thank for referring you? _____

If not referred, how did you hear about us? _____

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible For Payment of Account _____ Relationship _____

Mailing Address _____ City _____ State _____

Date of Birth ____/____/____ Phone # _____ Zip _____

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan _____

Policy or Group # _____ Subscribers Name (if different) _____ SSN of Subscriber _____

Name of Secondary Dental Insurance Plan _____

Policy or Group # _____ Subscribers Name (if different) _____ SSN of Subscriber _____

There will be a charge for broken appointments without 24 hours notice. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered. A finance charge will be added, if payment is not received within 90 days of service. I realize that failure to keep this account current may result in you being unable to provide additional dental services.

Signature _____ Date ____/____/____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date ____/____/____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records)including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

Name of Patient _____ Date ____/____/____

Signature of Patient, Parent or Guardian _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of Complete Dental Health to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Name of Patient _____ Date ____/____/____

Signature of Patient, Parent or Guardian _____

I understand that Complete Dental Health will make every effort possible to assist me with my insurance coverage. CDH allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, CDH will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or any other balance not paid by my insurance company. CDH requires my estimated portion at the time treatment is rendered.

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 24 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 24 hours notice, I will either be required to pay a fee of $50 per scheduled hour before a new appointment time will be made for me, or be put on a short call list.

Name of Patient _____ Date ____/____/____

Signature of Patient, Parent or Guardian _____