Sulens
DENTAL STUDIO

Sulens Dental Studio

750 Princeton Ave. • Zanesville, OH • 43701 • (740) 453-3089

PATIENT REGISTRATION

Thank you for choosing our practice to meet your dental health needs. Please complete both sides of this form so that we may provide you with the best possible care.

Date _____

Patient Name _____ Date of Birth _____ Sex: □ Male □Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Soc. Sec. # _____

Email Address _____ Marital Status: □Single □Mar □Sep □Div □Wid

Employer _____ Occupation _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Person to Contact in Case of an Emergency _____ Phone _____

Preferred Pharmacy _____ Phone _____ How did you hear about us? _____

RESPONSIBLE PARTY

Person Responsible for Account _____Relationship _____

Address _____ City _____ State _____ Zip _____

Phone _____ Employer _____ Soc. Sec. # _____ Date of Birth _____

INSURANCE INFORMATION

Primary Dental Insurance

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Soc. Sec.# _____ Insurance Company _____

Group # _____ Policy/ID # _____ Ins Co Phone _____

Ins Co Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Soc. Sec.# _____ Insurance Company _____

Group # _____ Policy/ID # _____ Ins Co Phone _____

Ins Co Address _____ City _____ State _____ Zip _____

Appointment Policy

Because of the level of service we provide, we reserve time for individual patients. Office hours are by appointment and we value your time. While we understand that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments and provide adequate notice if unable to do so in order for the office to have the opportunity to reschedule that time with another patient who has a true dental need. When an appointment is scheduled, it is considered a confirmed

appointment. Appointment reminders are provided as a courtesy to patients. If you cannot make an appointment as scheduled, please notify the office at your earliest convenience. **If you are unable to make your scheduled appointment, we request a minimum 24-hour cancellation notice.**

Upon a patient's first cancellation in less than 24 hours of the scheduled appointment, we will inform the patient of our cancellation policy and no fees will be assessed as long as the appointment is rescheduled promptly. After this, any cancellations made less than 24 hours prior to the second appointment may receive a fee of $25. As always, if you cancel 24 hours in advance by talking **directly** to our office staff (rather than leaving a voicemail, sending an email or a text), no fee will be charged.

Broken or missed appointments affect many people. If a patient has two (2) or more broken/missed appointments or two (2) cancellations with less than 24 hours notice, our office reserves the right to not schedule subsequent appointments.

We appreciate your understanding and consideration regarding our appointment policy. If you have any questions or concerns, never hesitate to ask.

□ I have read and I agreed to honor this appointment policy.

Financial Policy

Our GOAL is to provide you and your family with the Best Quality Care available, while simultaneously fostering a Great Relationship. To make this goal a reality takes Commitment from Everyone. Here's how YOU CAN HELP!!

PAYMENTS

To maintain the outstanding care you receive and prevent potential misunderstandings; ***we ask all of our patients to agree and adhere to paying for their dental treatment at the time of service****. With this agreement in place, our relationship WILL FLOURISH!!*

WE ACCEPT:

• **CASH/CHECKS** – Patients who are self-pay will receive a 5% DISCOUNT when treatment is paid IN FULL by cash or check AT THE TIME OF SERVICE.

• **CREDIT/DEBIT CARD** – We accept VISA, MasterCard, DISCOVER and AMERICAN EXPRESS as well as HSA/Flex Cards.

• **CARECREDIT** – CareCredit is a healthcare credit card that makes your treatment possible today!! It is designed for your health, beauty, and wellness needs. With many special financing options, you can avoid paying interest by making minimum monthly payments and paying the full amount due by the end of the promotional period. See www.carecredit.com for more details.

INSURANCE

If you have dental benefits here are some important things you should know…

• *BENEFITS* – Keep in mind that dental benefits do not typically cover the entire cost of treatment. They work more like a scholarship. They are there simply to assist you financially.

• *ESTIMATES* – We will do our best to accurately estimate your patient portion based on the most up-to-date information we have. But, it is only an estimate!! Insurance companies will make their payment determinations based on factors we may not be aware of.

• *RESPONSIBILITY* – If you choose, we will bill your insurance company as a courtesy to you. However, the responsibility to pay is between you and your insurance company. We suggest you take as much interest in making sure your insurance company follows through with their obligation to you as we do. Remember, ultimately you and only you are responsible for all charges incurred in our office.

□ I have read and I agreed to honor this financial agreement.

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care, to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (Parent/Guardian if minor) *Date*

Staff/Doctor's Signature *Date*