about you

Legal Name _____ **Birthday** _____

Preferred Name _____

Email _____

Phone Number (___) _____

Opt into appointment reminders? ◯ *Yes, text* ◯ *Yes, email* ◯ *Yes, text & email* ◯ *No*

Home Address _____

Employer _____ **Social Security Number** ___-___-____

Emergency Contact _____

Emergency Contact Phone Number (___) _____

Gender *select all applicable*

☐ Male ☐ Female ☐ Nonbinary ☐ Agender ☐ Other _____

Pronouns *select all applicable*

☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

How did you find us?

◯ Google ◯ Insurance Provider ◯ Advertisement ◯ Existing Patient _____

If you were referred by an existing patient, please let us know who referred you so we can send them a gift card to say thank you!

stellar smiles

insurance

Primary Insurance Policy

Dental Insurance Company Name

Policy Holder *Is the Policy Holder the patient?* ◯ *Yes* ◯ *No*

Policy Holder Date of Birth **Insurance ID #** **Group #**

Policy Holder Employer **Patient Relationship to Policy Holder**

Secondary Insurance Policy

Dental Insurance Company Name

Policy Holder *Is the Policy Holder the patient?* ◯ *Yes* ◯ *No*

Policy Holder Date of Birth **Insurance ID #** **Group #**

Policy Holder Employer **Patient Relationship to Policy Holder**

assignment of benefit

We estimate insurance coverage before your visit based on information your insurance company provides to us. We collect any co-pays at the time of service, and file a claim with your insurance company for their portion of the balance. Insurance payments are normally received within 30 to 60 days. Any unpaid balances after 180 days are your responsibility and are due at that time regardless of the original estimate of insurance benefits. A completed claim form or copy of your insurance card will need to be kept on file in our office for billing purposes. We try to answer any questions you may have about your insurance company or your coverage, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefit: Please read and sign to give our office permission to bill your insurance on your behalf:

I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Stellar Smiles of the insurance benefits otherwise payable to me.

Name _____ **Date** _____

billing policy, consent for treatment, and payment

Payment is due at time of service. We accept cash, check, Visa, Discover, MasterCard, American Express, and CareCredit. Returned checks are subject to a $25.00 fee. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 90 days. Past due balances over 90 days, regardless of insurance, are subject to a billing charge of $5.00 per month. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

financial agreement and authorization for treatment

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical service rendered to my family or me, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

NOTICE: *Do not sign this agreement before you read and agree to the conditions set form.* You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT:

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or their agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

Name _____ Date _____