Carolina Avenue Dental Care
Patient Information Form

Patient Name: _____
Birth Date: _____ Social Security #: _____
Home Address: _____
City: _____State: _____ Zip: _____
Home# _____ Cell#_____
Email: _____
Parent or legal guardian: _____

Whom should we contact in case of an Emergency: _____
Phone: _____
Relationship to Patient: _____

Primary Dental Insurance
Name of Insurance Co: _____
Name of Subscriber: _____
Subscriber Employer: _____
SSN of Subscriber: _____
Birth Date of Subscriber: _____

Secondary Dental Insurance
Name of Insurance Co: _____
Name of Subscriber: _____
Subscriber Employer: _____
SSN of Subscriber: _____
Birth Date of Subscriber: _____

Office Policies and Procedure

___Payment is due when services are rendered. We accept cash, checks and all major credit/debit cards. We also accept Care Credit. In office financing is NOT available.

___I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. **We can NEVER guarantee payment by your insurance company.** The insurance company's contract is with you and your employer.

___Delinquent account procedure: Statements are sent monthly. Once balance is 90 days past due, a phone call will be placed and the last statement will be mailed. If payment is not received within 10 days, the account will go to collections. **Payments MUST be paid in full before any other appointments can be made.**

___Appointments are made by you in accordance with your schedule. We understand that "life" happens but as a courtesy to us and our other patients please give us at least 24 hour notice if you must reschedule your appointment , so your previously reserved time can be given to another patient in need of dental treatment**. If you "Cancel" with less than 24 hour notice or "no-show" for your appointment you will be charged a $25 broken appointment fee**.

___I certify the information on the Patient Information Form is true and correct to the best of my knowledge. **I will notify Carolina Avenue Dental Care of any changes in my health status or any changes in the above information.**

___My signature below also acts as my permission to have Carolina Avenue Dental Care perform the procedures or treatments that they have reviewed with me. I also authorize them or their assignee to bill my insurance company for the procedure or treatment on my behalf. This acts as my signature on file for her or her assignee to act on my behalf for any purposes she deems necessary in relationship to my care.

Signature of Patient/Guardian: _____ Date: _____