PATIENT INFORMATION

PATIENT NAME: _____

Please complete the following information (please print clearly):

Pt is an Adult ☐ Child ☐ Guardian's Name: _____

Client information & health history completed by: _____ Date: _____

Relationship to Patient: _____ Phone # _____

Email address: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

Street # Street Name Unit # City Postal Code

Long term care or hospital facility: _____ Room #: _____

Last dental visit: _____ Last dental hygiene visit: _____

Dentist's Name: _____ Phone: _____

Do you have a hip/knee or joint replacement, or require antibiotics prior to dental cleanings for any other reason? _____

Who referred you to Preferred Dental Hygiene Services? _____

Do you have dental insurance: ☐ Yes ☐ No

If YES – Policy Holder Name: _____ Date of Birth: _____

Relationship to patient: _____ Insurance Company: _____

Policy /Group # _____ I.D. or certificate # _____

Person responsible for payment of account: _____ Relationship: _____

Phone # Home: _____ Work: _____ Cell: _____

Employer: _____ Payment preference: VIS☐ MC☐

Best time for appointments: ☐ Morning ☐ Afternoon ☐ Either

Primary Contact Person: _____ Relationship_____

Address: _____

Phone #: Home: _____ Work: _____ Cell: _____

Second Contact Person: _____ Relationship_____

Phone #: Home: _____ Work: _____ Cell: _____

Signed: _____ Print Name: _____ Date: _____

ACCOUNTS ARE DUE WHEN SERVICES ARE RENDERED. FOR YOUR CONVENIENCE PAYMENT MAY BE MADE BY VISA OR MC OVER THE PHONE

For Office Use

Appointment booked: Provider: _____ Date: _____ Time: _____

FINANCIAL AGREEMENT

Thank you for choosing us to provide dental care for the person listed on the reverse side of this form. We consider it an honour to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our office.

PAYMENT POLICY

- Payment for services is expected the day of treatment (unless otherwise arranged).
- We accept cash or cheques.
- As mentioned above, we will be happy to complete dental insurance forms for you to submit, but it is your responsibility to pay us, and the insurance company will reimburse the client directly for what they cover.

If you have pre-arranged to pay by cheque, a statement will be mailed to you, and payment is expected within 14 days of the statement. If payment is late more than 3 times, we will no longer accept payment by cheque. A $45.00 charge will apply when a cheque is returned by the bank for any reason

DENTAL INSURANCE

We will be happy to provide you with a completed dental insurance claim form for any services provided. All insurance payments will be reimbursed to the client – not to Preferred Dental Hygiene. We do not accept assignment.

- In order for us to complete the insurance claim form for you, you must provide us with the insurance information company, group and ID number, and any other information necessary to verify the patient's coverage and to file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and the patient, not the insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another. We adhere to the current Ontario Dental Hygienist's Fee Guide.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment.
  Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for services are due at the time of Treatment, unless otherwise agreed upon.

**** Please note that some insurance companies will not pay for dental hygienist's services. Although this is rare, if you are unsure if your policy will pay for dental hygiene services by an independent dental hygienist, please check with them before the appointment. Please be aware that most insurance companies will not cover the institutional or home visit fee.**

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

CONSENT & AUTHORIZATION: I authorize dental treatment on _____ and agree to pay all related professional fees. I have read and understood this document in its entirety, outlining office policies and financial policies of Preferred Dental Hygiene Services. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name_____Signature_____

Relationship to Patient_____ Date_____

Are you the person legally responsible for this patient? Yes _____ No _____

Reviewed by staff member _____ Date _____