DENALI
FAMILY DENTISTRY

10160 Kenai Spur Highway Kenai, AK 99611

PATIENT INFORMATION

Patient's Last Name	First Name:	Middle:	Date of Birth: / /	Sex: ☐ Male ☐ Female
Mailing Address:	City:	State:	Zip:	
Home Phone No.:	Cell Phone No.: Ok to text? ☐ Yes ☐ No	Work Phone No.:	Email Address: Ok to email? ☐ Yes ☐ No	
Social Security No.:	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow	Preferred Pharmacy:		
Employer Name: ☐ Retired ☐ Self-employed ☐ Active Military ☐ Unemployed	Student: ☐ Yes ☐ No ☐ Full-time ☐ Part-time	How did you hear about our office?		
Emergency Contact:	Relationship:	Phone No.:		
Person responsible for bill:	Date of Birth: / /	Address (if different):	Phone No.:	

Primary Insurance	Secondary Insurance
Insured's Name (policyholder)	Insured's Name
Insured's DOB Relationship to pt	Insured's DOB Relationship to pt:
Employer	Employer
Insurance Co.	Insurance Co.
Insurance Co. phone #	Insurance Co. phone #
ID# Group #	ID# Group #

FINANCIAL POLICY

Thank you for choosing our dental office as your dental healthcare provider. We are committed to providing you with the highest quality dental care. The following is a statement of our Financial Policy, which we require you to read, agree to, and sign prior to any treatment. Please understand that payment of your bill is considered a part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, Visa/Mastercard, and CareCredit. Returned checks will be subject to a $30.00 NSF fee. All accounts over 60 days past due may be subject to a finance charge at the rate of 10.5% annually. All accounts over 120 days past due may be sent to a collection agency for processing. In the case it becomes necessary for our office to enlist a collection agency and/or legal assistance, you will be responsbile for any collection and/or legal charges (including finance, rebilling, collection or attorney fees) and all treatment will be suspended. Cancellations made less than 24 hours prior to the scheduled appointment may be subject to a cancellation fee. Patients that miss 3 or more appointments may be subject to dismissal.

As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid.

All charges you incur are your responsibility regardless of your insurance coverage. Our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

Our practice is committed to providing the best treatment for our patients and we charge what we consider to be usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

You are financially responsible for the dental services provided to you and/or your dependents. Your deductible and co-payment is due at the time of service unless other financial arrangements have been made. If your insurance company has not made payment within 60 days or your claim is denied, you will be responsible for paying the full amount at that time. We will cooperate fully with with the regulations and requests of your insurance company that may assist in the claim being paid.

By signing below, you are authorizing us to call you at any number provided for any lawful purposes.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient/Guarantor Signature **Date**