smilewave
IMPLANT & COSMETIC DENTISTRY

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Oceanside, CA 92056
760.758.3300

Patient Information Form

Please make sure to read, sign and date the back of this form.

STEP 1 Please start here. If a box does not apply, please enter N/A

Patient Name (Last, First, Preferred)

Street Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Date of Birth | Social Security Number

Male | Female | Single | Married

Email Address

Employer | Work Phone Number

Work Address

If filling out paperwork for your child:

Parent/Legal Guardian Name

Address, if different from your child

City | State | Zip Code

STEP 2 Insurance Information

Subscriber's Full Name

Group/Employer's Name

Dental Insurance Company

Subscriber's ID # | Subscriber's SSN #

Dental Insurance Address

Group Number | Effective Date

City | State | Zip Code

Customer Service Phone Number | Date of Birth

STEP 3 Referral Source & Emergency Contact Information

How were you referred to us?

Is a member of your family a patient in our office? Please list their names.

Would you like to be reminded of your appointments by: Email | Text Message | Phone Only

Emergency Contact Name

Emergency Contact Address

Home Phone | Work Phone | Cell Phone

STEP 4 Office Policies

Our practice understands that patients rely on their dental insurance to help defray the cost of dental services. We will be happy to assist you in obtaining the maximum benefits specified in your contract. As a courtesy to you, we will submit your claim to your insurance company and accept the assignment of payment.

We ask that your estimated payment and deductible be paid at the time of service.

Please understand that our follow up process is limited to re-billing your insurance company one time. We agree to be as prompt as possible in our processing steps, however, we will turn any unpaid insurance claims back to the patient for payment after 60 days.
Be advised, not all services are a covered benefit in all policies. Some insurance companies arbitrarily select certain services they will cover. In response to this, our office will submit a pretreatment estimate to your insurance company. In this way, we can obtain a much closer estimate of your insurance benefits to help you budget your out-of-pocket costs.

Please give us at least 24 hours for appointment changes. A $50 late cancellation fee may be billed to patient for repeated no-shows and late appointment changes.

STEP 5 Please Read Our Federal Truth-In-Lending Statement and Sign and Date Below

1. As a condition of your treatment by this office, financial arrangement must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

2. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

3. Patients who have dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our changes will be paid in full by an insurance company.

4. A service charge of 1.5% per month, 18% annually, on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service. Fee estimates for dental care can only be extended for period of six months from the date of the patient examination.

5. In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected by me, in writing, within the time for payment thereof, I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions that my be assessed by any collection agency retained to pursue this matter.

6. I grant my permission to you or your assignee to telephone me at home, on my cell phone and at my workplace to discuss matters relating to this form.

7. I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Smilewave Dentistry.

8. I certify that I have answered all questions on the form accurately. I hereby agree to abide by the conditions outlined there in.

Signature of Patient/Legal Guardian	Date