Landmark Total Dentistry

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle	Preferred:	☐Mr. ☐Ms. ☐Mrs. ☐Dr.

Marital Status (circle one) Single☐ Married☐ Divorced☐ Separated☐ Widowed☐	Birth date: / /	Sex: ☐M ☐F

Street address:	Social Security no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Whom may we thank for referring you to our office?

Has any member of your family ever been treated in our office?:

CONTACT INFORMATION

Home phone no.:	Cell phone no.:	Work phone no.:

Email address:

Which contact would you like us to use first? ☐Home ☐Cel ☐Work ☐Email	Where may we leave messages? ☐Home ☐Cell ☐Work ☐With family ☐Not With Family ☐Email

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:

Home phone no.:	Cell phone no:	Work phone no.:

INSURANCE INFORMATION

(If no insurance, please complete for responsible party)

Subscriber's Name:	Subscriber's S.S. no.:	Birth date: / /

Home phone no.:	Cell phone no.:	Work phone no.:	Email address:

Address (if different than above)

Employer:	Insurance Company

Patient's relationship to subscriber: ☐Spouse ☐Child ☐Self ☐Other_____	Group no.:	Subscriber ID no.:

OFFICE POLICY

Payment is due at the time services are rendered. A ***3.95% processing fee*** applies to debit and credit card payment transactions. The ***3.95% fee is waived*** when paying by ACH, cash or check. _____ (initial)

I authorize payment directly to the office of Landmark Total Dentistry. As a courtesy, we will submit necessary claims and documentation directly to your insurance company on your behalf.

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine; due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court fees. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). _____ (initial)

Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I hereby authorize this provider and its employees, agents, and assignees to contact me via Email, text, and calls. _____ (initial)

To the best of my knowledge, all the preceding information I have provided is correct. If I have any changes to my contact information or insurance coverage, I shall inform the doctor and staff at the next appointment without fail.

Patient or Responsible Party (please print)	Signature	Date