Tell us about yourself…

*Date:*_____/_____/______

Patient Name: ____
Last, First MI Preferred/Nick Name

Date of Birth: _________/__________/______________ Social Security # *(for insurance purposes)*: __________________________

Sex: ☐ Male ☐ Female

Phone *(Home)*: ____ *(Cell)*: ____

Email: ____

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name: ____ Phone: ____

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Married: ______________________________________

Spouse Name: ____
Last, First MI

Date of Birth: _________/__________/______________ Social Security # *(for insurance purposes)*: __________________________

Do you currently have dental Insurance? ☐ **YES** ☐ **NO** **Do you have a secondary policy?** ☐ **YES** ☐ **NO**

IF NO:

I am interested in learning more about:

☐ Robinson Dental's In-Office Savings Plan

☐ Care Credit Financing

☐ NONE OF THE ABOVE, I will be paying by cash, check, or VISA/Mastercard

IF YES:

Insurance Company: ____

Primary Subscriber: ____

Employer's Name: ____

ID # or Subscriber SSN: ____

Primary Subscriber Date of Birth: _______________________

HIPAA Privacy Patient Consent:

- ☐ I have read a copy of this office's Notice of Privacy Practices.
- ☐ I have chosen not to read a copy, but I am aware of this office's privacy practices.

With whom may we discuss your dental health and/or account with? ____

Relationship to Patient: ____

**Without this written consent, we cannot discuss your treatment or account with anyone other than you.*

How did you hear about our office?

☐ Family/Friend: ______________________ ☐ I live in town/Drive by your office ☐ Google/Internet search

☐ Event: __________ ☐ I received your mail What made you decide to come in? ______________

Our Responsibility…

…

Providing the highest quality dental care involves keeping you informed so you can make good decisions about your dental health. We perform a wide variety of dental procedures here and we do realize that things can sometimes get a little confusing. We want you to know that you have a right to ask questions about anything you don't understand. We will be pleased and frankly, delighted, to answer your questions.

As a courtesy, we will gladly file your insurance claim to your insurance company; however, your insurance contract is between you, your employer and the insurance company. If you have any concerns or disputes on what the insurance company covers, we ask that you contact them directly as we cannot alter you're agreed upon contract.

Please take note…

- A charge of $25.00 will be assessed for all returned checks.
- We reserve the right to charge $30 for appointments cancelled or broken without 24 hours advance notice.
- Balances over *90 days old* will be referred to **small claims court**. In the event you are sent to court, there will be a 50% charge added to your account and you will be responsible for all court fees.

I certify that I have read and understand this form as well as my financial responsibilities, and that I have the right to ask questions before agreeing to any procedure(s). I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment. I am aware that the practice of dentistry is not an exact science and I acknowledge that no written or oral representations, warranties or guarantees have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

_______________________________ _______________________

PRINT Name of Patient, Parent or Guardian Relationship to Patient

_______________________________ _______________________

Signature of Patient, Parent or Guardian Date

Family caring for family…

Dr. Elizabeth Robinson, DDS
Dr. Scott Robinson, DDS
Dr. Malavi Patel, DMD
Dr. Derek DeVries, DDS
Dr. Jake Streng, DDS
Dr. Alex Hoelzel, DDS
Dr. Jeff Cartwright DDS
Dr. Steve Feddick DDS

502 W. Randall St.
Coopersville, MI 49404

899 Reno Drive
Wayland, MI 49348

888-WE-C-U-NOW
888-932-8669

Info.robinsondental@gmail.com

**I give my consent to Robinson Dental for treatment of myself. I authorize my insurance benefits to be paid directly to Robinson Dental. I realize that I am responsible to pay non-covered services and/or any co-pay/deductible. Payment is due at the time of services rendered. If for some reason my account is sent to a collection agency or an attorney for non-payment, I agree to pay all collection and court costs, attorney fees, and other costs incurred. I hereby authorize the release of pertinent medical information to insurance carriers for payment purposes. I am aware that it is my obligation to know my insurance company's policies and coverages.

Billing and Insurance: Our professional relationship is with you, and not with any insurance carrier. You are responsible for paying the full cost of treatment when it is rendered unless it is covered by insurance. We accept most major insurance companies and we will submit all authorized claims to the designated insurance carrier, provided we have received all required information. For your convenience, we will request verification of your co-pays and deductible from your insurance carrier. It is your responsibility to confirm your co-pay and deductible, and to make required payments at the time of each appointment (we accept cash, personal check, Visa, MasterCard, Discover and Care Credit). We will charge a $25.00 fee for any returned check. Note that quoted deductibles and co-pays are provided by your insurance carrier as **estimates only, and do not guarantee payment by your insurance carrier. Some services or treatments might not be covered benefits under your insurance plan. You are responsible for payment of any services or treatments not covered by your insurance carrier.

**Missed Appointments: You will not be billed for missed appointments if you give us at least 24 hour notice of cancellation, so that we can schedule another patient. Failure to give a 24 hour notice, or a no call/no show will result in a $30.00 charge.

**Past Due Account: Accounts not paid within 30 days are considered past due. You are responsible for payment of any costs we incur in collecting past due accounts (such as collection agency and attorneys fee). Effective June 1st, 2015, all outstanding balances older than 90 days will be subject to a 6% monthly finance charge.

I understand and agree to the terms of this document, I authorize Robinson Dental to bill my insurer(s) for all services rendered and I authorize my insurer(s) to make payment directly to Robinson Dental.

This authorization will be effective for a period of one year from the date of signing.

X____ Date_______/______/___________

Signature of Responsible Party **(must be over 18 years old)**