Maupin & Brown Dentistry

Patient Information Form

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

Date _____

Name _____

Wishes to be called_____

SS# / SIN_____ Email _____

Birthdate_____ Driver's License _____

□ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Referred by _____

Cell Phone _____ Home Phone _____ Work Phone _____

Guardian Information (Please Complete if Patient is Under 18 Years of Age)

Who is responsible for the account?

Name

Relationship to patient _____

SS# / SIN_____ Email _____

Birthdate_____ Driver's License _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Cell Phone _____ Home Phone _____ Work Phone _____

Contact Info

Cell Phone_____

Home Phone _____

Work Phone _____

Where do you prefer to receive calls? Home □ Work □ Cell □

When is the best time to reach you? Time _____ AM PM Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

Dental Insurance Information

Primary Insurance	Additional Insurance
Policyholder Name _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Policyholder Birthdate _____	Insured's Birthdate _____
SS # /SIN _____	SS# / SIN _____
Employer _____	Employer _____
Date Employed _____	Date Employed _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____
Employee/Cert. # _____	Employee/Cert. # _____
Ins. Co. Address _____	Ins. Co. Address _____
Deductible _____	Deductible _____
Amount Already Used _____	Amount Already Used _____
Max. Annual Benefit _____	Max. Annual Benefit _____

Cancellation Policy

Although we know that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments so that our hygienists, doctors, staff and other patients can rearrange their schedules. If you are unable to make your scheduled appointment, we request a minimum 24 hour cancellation notice. Therefore, our cancellation policy is that, upon your first cancellation in less than 24 hours of your schedule appointment, we will inform you of our cancellation policy and no fees will be assessed. After this, any cancellations made in less than 24 hours of the scheduled appointment will receive an assessed fee of $50 per appointment that you have scheduled. As always, if you cancel 24 hours in advance by talking directly to our office staff , no fee will be charged.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment will be due in full at each appointment. If this is a problem please let us know immediately.

Cash _____ Personal Check _____ Credit Card _____ Care Credit _____

Late Fees

If I do not pay the entire new balance 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 (where allowed by law). I realize that failure to keep this account current may result in the stoppage of additional dental services except for dental emergencies or where there is pre-payment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Photo Release

I consent to photos as related to my dental health and give the office permission to photograph me as needed for my dental needs & records. Photos will be for in-office use only.

Authorization Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I confirm all information completed on this form is correct to the best of my knowledge and agree to the terms listed.

X_____ _____

Signature of Patient or Parent/Guardian if a Minor Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.