NEW PATIENT / FINANCIAL POLICY

Welcome to **Smile Surfers Kids Dentistry** and thank you for choosing **Smile Surfers** as your child's dental specialist!

PATIENT INFORMATION									
PATIENT'S FULL NAME	**SEX**		**DATE OF BIRTH**	**PATIENT'S FULL NAME**	**SEX**		**DATE OF BIRTH**		
	M	F	/ /		M	F	/ /		
	M	F	/ /		M	F	/ /		

WHOM MAY WE THANK FOR REFERRING YOU?

PARENT & RESPONSIBLE PARTY							
MOTHER	**STEPMOTHER**	**GUARDIAN**	_____	**FATHER**	**STEPFATHER**	**GUARDIAN**	_____
FULL NAME				**FULL NAME**			
EMPLOYER				**EMPLOYER**			
OCCUPATON				**OCCUPATION**			
DOB		**SSN**		**DOB**		**SSN**	
ADDRESS				**ADDRESS**			
CITY	**STATE**	**ZIP**		**CITY**	**STATE**	**ZIP**	
PHONE #	**EMAIL**			**PHONE #**	**EMAIL**		

EMERGENCY CONTACT INFO		
NAME	**RELATIONSHIP TO PATIENT**	**PH #**

DENTAL INSURANCE INFORMATION			
IS YOUR CHILD COVERED BY A PRIVATE DENTAL INSURANCE? YES NO		**IS YOUR CHILD ELIGIBLE FOR STATE INSURANCE? YES NO**	
PRIMARY INSURANCE		**SECONDARY INSURANCE**	
POLICYHOLDER'S NAME		**POLICYHOLDER'S NAME**	
INSURANCE NAME		**INSURANCE NAME**	
GROUP #	**ID #**	**GROUP #**	**ID #**
INSURANCE PHONE #		**INSURANCE PHONE #**	

Payment: Payments and/or Co-payments for treatment are due at the time services are rendered. We accept checks, Care Credit, and most credit cards. **Out of Pocket Specials: 20%** discount for non-insured payment (does not apply to reduced fee plans, insurance, use of Care Credit, or to certain services). Please inquire at the front desk for information. **Financial Responsibility:** The parent or guardian who brings the child for their visit is responsible for payment at time of visit, independent of what a divorce decree may say. **Insurance:** In an effort to keep dental costs down while maintaining a high level of professional care, our financial policy is payment due at time of service. We file insurance claims as a courtesy to our patients. You are responsible for deductibles, co-payments, coinsurance and dispute resolution with your insurance company. **Services Not Covered:** Some insurance policies have coverage limitations on these procedures. Patients will be responsible for any balance incurred as a result of a coverage limitation, co-insurance or deductible. Although your policy may state that you have 100% coverage on either preventative or basic services be aware that your yearly deductible may apply. We ask that you pay your account balance within 60 days from the date of service. **Cancellations: Please contact us 48 hours prior to your child's appointment if you need to reschedule.** If you **fail to show** for two scheduled appointments, you will regretfully receive a termination letter from our office.

I certify that the information I've provided is correct to the best of my knowledge and understand that it is my responsibility to inform this office of any changes. It is our policy to make definite financial arrangements with you before treatment starts. A member of our team will be happy to answer any questions.

Print name: _____ Relationship to patient: _____

Signature: _____ Date: _____