TATE FAMILY DENTISTRY

John Tyler Tate, DDS
3101 E State Hwy 114, Ste A
Southlake TX 76092
Phone: 817.481.6364 Fax: 817.329.2296
www.TateFamilyDentistry.com

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name _____ Middle Initial _____Last Name _____ Preferred Name _____

Address _____ City _____ State ____ Zip _____

Responsible Party (If Patient is Minor) _____

Billing Address (If Different) _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Best time & Number to contact you _____

Date of Birth (mm/dd/yy) ___/___/____ Age _____ Social Security # (For Insurance) _____

How did you hear about us? _____ Emergency Contact Name/Number _____

INSURANCE INFORMATION

Employer of Primary Insurance Holder _____ Employer Phone # _____

Primary Insurance Company _____ Phone # _____

Policy ID# _____ Group # _____

Employer of Secondary Insurance Holder _____ Employer Phone # _____

Secondary Insurance Company _____ Phone # _____

Policy ID# _____ Group # _____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I, _____, authorize the Doctor to take radiographs, study models, photographs, records or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent the Doctor to employ any such assistance as he/she deems appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations rendered to my insurance company, consulting professionals and others I approve by mail or secure electronic means.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. Last minute cancellations and missed reservations may incur a $25.00 broken appointment fee. To avoid this charge, kindly give 48 hours notice to our office. We do understand, on occasion, last minute things occur. If we both take our commitment to each other seriously, these issues are often avoidable.

I certify that the information given is correct and current. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

<u>Pre-Payment Discount</u> – A discount of 4% is given to Cash or Check, if treatment is paid in full, 7 or more days prior to treatment.

<u>We Accept</u> – Visa, Master Card, Discover and American Express; however no discounts will be given to these forms of payment. Financing is available through CareCredit©.

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(Patient or Guardian Signature) (Print Name) (Date)