Patient Information

Patient Name: ____ Nickname_________________
Last First Middle

MailingAddress: ____
Street City State Zip

Physical Street Address: ____
(If different from above) Street City State Zip

E-mail: ____

Home Phone # ____-____-_____ Cell Phone # ____-____-______Work Phone # (if ok to call you there) ____-____-______ext._____

Birthday: ______/______/______ Social Security # ______/______/______

Employer/School: ____ Position/Grade/Rank ______________

Emergency Contact Name: ___________________________ Phone # ____-____-____ Relationship: __________________________

Who may we thank for referring you to our office? ____

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Insurance

***As a courtesy our office will bill your dental insurance carrier. If you would like to utilize this service and to ensure the proper billing of your dental claims we ask that you provide us with the information below.**

***Primary** Dental Insurance Policy Holders Name: ____
First Last Middle

Social Security #: ______-______-______ Insurance ID # _________________________ Employer: __________________________

Dental Insurance Company: ____

Claims mailing address: ____
Street or P.O. Box# City State Zip

Your relation to policy holder: ________________________________

***Secondary** Dental Insurance Policy Holders Name: ____
First Last Middle

Social Security #: ______-______-______ Insurance ID # ___________________________ Employer: ________________________

Dental Insurance Company: ____

Claims mailing address: ____
Street or P.O. Box# City State Zip

Your relation to policy holder: ________________________________

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The information I have provided on this page is accurate to the best of my knowledge:

Patient or Guardian Signature: ____

Printed Name: ____ Date: ____/____/______

Craig Pearce D.M.D
5920 Evergreen Way, Suite E
Everett, WA 98203

Information About Your Dental Service

We feel strongly that our patients deserve the best care. In an effort to provide high quality dental care we would like to share information with you about our office policies.

- If you do not have any dental insurance benefits, we require payment in full at time of service. We accept Cash, Check, Debit, Visa, MasterCard, Discover, American Express or Care Credit.

- As a courtesy, we will bill your dental insurance for you; this does not make us responsible in any way for knowing all the details of your contract. In some cases, the design of your plan may limit your benefits and may not cover all necessary treatment. We encourage you to read your benefit booklet which your employer should provide or you should have access to.

- If you choose for us to bill your dental insurance, and the services you are receiving are covered at less than 100%, you will be asked to pay your estimated portion on the day of service. Any good faith estimate of dental benefits we give you, either written or oral, is just an estimate and **not a guarantee of benefits**.

- When you make an appointment at our office, we reserve that time just for you. If you call at the last minute or fail to show up for the time you've reserved, that time goes unused. With the proper notice, we can offer that time to someone else in need. We ask that you kindly give us **48 hours notice to reschedule or cancel** an appointment time you have reserved with us. If appropriate time is not given then we reserve the right to charge your account $75.00 per hour reserved.

- Accounts over 90 days will be charged 1.5% interest per month. Accounts over 120 days will be sent to a collection agency.

- There is a charge of $50.00 for checks returned due to insufficient funds.

Treatment and Insurance Payment Authorization

I hereby authorize payment directly to my Doctor's office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize my Doctor's office to administer such medication and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. I certify that all of the above information is correct and I have read and will subscribe to the office policies.

Signature: _____ Date: _____