Summercrest Dental
FAMILY DENTISTRY

S. ALEXANDER MARRERO, D.D.S., P.C.

Welcome To Our Office *Please Print* Date _____

PATIENT'S LAST NAME	FIRST	INITIAL	PREFERRED NAME

SS#	ODL#	MARITAL STATUS (S M W D O)	BIRTHDATE	AGE	HOME PHONE #
			/ /		

STREET ADDRESS	CITY	STATE	ZIP CODE

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUS PHONE#, EXT.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

REFERRED BY (NAME)	FAMILY PHYSICIAN (NAME)

FRIEND / FAMILY ☐ DOCTOR ☐ INS. CO. ☐ OTHER:

SPOUSE'S / PARTNER'S NAME	SS#	BIRTHDATE / /

SPOUSE'S / PARTNER'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUS PHONE #

IF PATIENT IS A MINOR, PLEASE COMPLETE MOTHER	BIRTHDATE	EMPLOYED BY	BUS PHONE #
SS#	/ /		
FATHER	BIRTHDATE	EMPLOYED BY	BUS PHONE #
SS#	/ /		

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE)	PHONE #

PRIMARY INSURANCE NAME AND ADDRESS OF COMPANY	EFFECTIVE DATE	PHONE #

SS# OR ID#	SUBSCRIBER	GROUP NAME AND #

SECONDARY INSURANCE NAME AND ADDRESS OF COMPANY	EFFECTIVE DATE	PHONE #

SS# OR ID#	SUBSCRIBER	GROUP NAME AND #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize that payment of dental benefits be made directly to Dr. Marrero for any services furnished to me by this dentist. I understand that my signature requests that payment be made and authorizes release of medical information or any information relating to this claim in order for this claim to be paid. I understand that I am responsible for all costs of dental treatment.

Signature _____ Date _____

Current Information ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name_____ Date_____

Date of Birth_____

MEDICAL HISTORY

1). Have you been a patient in a hospital during the past 2 years? Yes___No___
Reason_____

2). Have you been under the care of a physician during the past 2 years? Yes___No___
Reason_____

3). Have you taken any kind of medicine or drugs (including recreationally) during the past year?
Yes___No___Name of drug_____

4). Are you allergic to penicillin or any drugs or medicine? Yes___No___
Name of drug_____

5). Are you allergic to or had any reaction to any anesthetic? Yes___No___

6). Have you ever had excessive bleeding requiring special treatment? Yes___No___
Explain_____

7). Have you had prolonged coughing? Yes___No___

8) Approximate date of last physical examination_____
Physician's name and address_____

9). Circle any of the following that you have had or now have:

AIDS	congenital heart lesions	high blood pressure
allergies	diabetes	kidney treatment
arthritis	epilepsy	psychiatric treatment
heart murmur	sinus trouble	herpes
asthma	heart trouble	thyroid
cancer treatment	hepatitis	tuberculosis
venereal disease	rheumatic fever	mononucleosis

10) Have you had any other serious illnesses? Yes___No___Explain_____

11) IF FEMALE: Are you pregnant now? Yes___No___ Nursing? Yes___No___
Taking birth control pills? Yes___No___

DENTAL HISTORY

1) Date of last dental visit_____Reason for visit?_____

2) Do you have any specific dental problems? Yes___No___Explain_____

3) Any unhappy dental experience? Yes___No___Explain_____

4) Any injuries to mouth, teeth, head? Yes___No___Explain_____

5) Any unusual speech habits? Yes___No___Explain_____

6) Have you lost any permanent teeth? Yes___No___

7) Have missing teeth been replaced? Yes___No___

8) Orthodontic appliances worn now or ever worn? Yes___No___

9) Is dental floss used? Yes___No___

This information was given by:_____

FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care or the care of your child.
We consider it an honor. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable", all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Care Credit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date to avoid finance charges.
- If the insurance company does not pay in full within 60 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECITON FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.75% on the balance then unpaid and owed will be assessed each month in addition to a $15.00 billing fee, until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days of our first billing statement to you will be sent to our collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt including an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 36 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 36-HOUR NOTICE IS NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least thirty-six (36) hours in advance to avoid a missed appointment fee of $75. We may waive this fee if we feel your circumstances warrant a one-time waiver. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your records or radiographs for a nominal duplication fee of $30.00

CONSENT AND AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining the office and financial policies of Summercrest Dental. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name_____

Signature_____

If patient is a minor child, relationship to child_____

Date_____

Are you the person legally responsible for this child? Yes_____ No_____

Reviewed by Staff Member_____ Date_____