PATIENT INFORMATION **T. Daniel Haeussner, DMD**

Today's Date _____/_____/_____

Patient's Name _____ Sex ☐ M ☐ F Date of Birth _____/_____/_____
First MI Last

Home Address _____ Phone # (_____) _____
Street City State Zip Home #

Social Security # _____ E-mail address _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced Are you a full time student? ☐ Yes ☐ No School Name _____

Other Phone Numbers (_____) _____ (_____) _____ (_____) _____
Work # Mobile # Pager #

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

How did you hear about our office? _____

Who should we contact in case of emergency? _____ (_____) _____
Name Relationship Phone #

☐ Spouse ☐ Parent if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____ SS# _____
Name Relationship

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's SS# and/or ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card or please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union # if any _____

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL INSURANCE: Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file your secondary claims for you and the payments from your secondary can be assigned to you. We collect estimated portions calculated by our computer system up front; if there is any remaining balance after receiving this portion plus any portion your primary carrier pays, it will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you and subject to interest charges (21% APR). Thanks for your understanding.

FINANCIAL AGREEMENT (FOR ALL PATIENTS): Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard, American Express, or other outside financing. Any balances over 90 days old will be assessed a finance charge of 21% APR. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

I have read and understand the above financial policies. I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____