TIFFIN FAMILY DENTISTRY

Good Is Not Enough ~ Excellence is a Must

Patient Name: _____Preferred Name: _____
(First, Middle Initial, Last Legal Name)

Birth Date: _____ Married___ Single ___ Minor ___ Other ___

If a minor, name of parent or guardian: _____

Preferred Phone: _____ Work: _____

Alternate phone for appointment reminders: _____ Email Address: _____

May we leave a voicemail? **Yes No** May we leave a message with alternate contact person? **Yes No**

Would you like to receive text message reminders? **Yes No** Would you like to receive email reminders? **Yes No**

Street Address_____

City/State/Zip_____

Emergency Contact Person: _____Phone: _____

Relationship of emergency contact: _____

✓ ***Check with the front desk and make sure we have a copy of your current photo ID & Insurance Card.***

Please be aware that we collect the *estimated* patient responsibility amount for insurance-covered service portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file and submit your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service. A completed claim form and/or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance; however, you may need to contact your insurance company directly for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefits: Please read and sign to have our office file and submit your insurance claim. I authorize the release of information necessary to process my insurance claim. I understand that I am financially responsible for all costs associated with my dental treatment, regardless of my insurance coverage. I hereby authorize payment of any insurance benefits otherwise payable to me to be made directly to Christopher D. Tiffin, D.D.S., P.C. and/or Tiffin Family Dentistry.

X Signature of Patient, Parent, or Guardian: _____Date:_____

FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to my family or me, I/we agree to pay reasonable attorney's fees and/or other such court-approved costs, in addition to the amount owed, if the court determines those costs are appropriate. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

X Signature: _____Date: _____

We require at least 48 hours' notice for appointment cancellations or rescheduling. Changes made with less than 48 hours' notice may be subject to a cancellation fee and/or limited appointment availability.