Jeffery Spilman D.D.S

Patient Information

Name:_____ Birthdate:___/___/___ Gender: M ○ F ○

Address:_____City:_____ State:_____ Zip_____

Cell #: _____ Home #:_____Email:_____

SSN:_____-_____-_____ How did you hear about us?_____

In case of emergency: _____Phone #:_____

Responsible Party Information

Person responsible for account: _____ Relation to Patient_____

Birthdate: ___/___/___ Address: _____City_____ State:_____ Zip: ____

Currently a patient in our office? Y ○ N ○

Insurance Information

Policy Holder: _____ Birthdate:____/____/____

Employer:_____ Insurance company: _____

ID#_____ Relation to patient: Self/Spouse/Child

Please present Insurance card and photo id to receptionist.

Financial Policy

FULL PAYMENT is due at the time of service. For your convenience we accept cash, check, CareCredit, & all major credit cards. A fee of $50 will be charged for returned checks.

As a courtesy our office will bill all services to your insurance. You must realize however, that

- Your dental benefits are under contract between you, your employer, & the insurance company. We are not a party to that contract.
- Our fees generally are not fully covered by the maximum allowance determined by your carrier and all dental service's may not be covered by your carrier, some procedures receive no benefits.
- You are responsible for all fees incurred for services rendered to you.

If your insurance company has not paid for the claim within 45 days the balance will automatically be billed to you.

Cancellation and No Show Policy: Since we reserve time for you we kindly request at least 48 hours notice when cancelling or rescheduling an appointment. **No shows, oversight, or disregard to our time may result in a $35 charge**.

Patient Signature:_____ Date:_____