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Avon Village Family Dentistry

Patient Information (Please Print)

Date____ /____ /_____

Name _____ Preferred Name_____

Home Phone (___) _____Cell (___) _____ Work Phone (___) _____

Email Address_____ SS# ____-____-_____ D.O.B _____

Address_____City_____ State ____ Zip _____

I prefer to be reminded/confirm my appointments via: phone text email (circle one)

Dental Insurance Information

Insurance Holder's Name _____Date of Birth _____

Employer_____ I.D. Number _____

Insurance Company _____Group Number _____

Address _____ Phone #:_____

Medical Insurance Information

Insurance Holder's Name _____Date of Birth _____

Employer_____ I.D. Number _____

Insurance Company _____ Group Number _____

Address _____ Phone #:_____

I hereby authorize all insurance payments to be made directly to the provider _____

Patient Signature or Guardian

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. Any balance not received in a timely manner will be sent to a collection agency. The patient will be responsible for their balance plus a 15% collection fee.
Please note that an appointment time has been reserved for you; and we need at least 24 hrs. notice for cancellations. If we do not receive ample notice a $50 chair fee will be applied to your account.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of her staff, responsible for any errors or omissions that I may have made in the completion of this form, and I agree to notify the office of any changes.

I, _____understand the above policy as stated.

Patient Signature or Guardian