THIRD STREET DENTAL
DR. MELISSA SKINNER

PERSONAL INFORMATION

First Name____________________________ Last Name _________________________________Date of birth___________________

Address ____ City____________________ Prov______Postal Code_______

Home phone ______________________ Cell phone ___________________________Work phone______________________________

Preferred contact number? _H / C / W Email __________________________________ How did you hear about us? ________________

Person to contact in case of emergency ____Phone ____________________________

Do you have dental insurance? **YES / NO** Do you have secondary dental insurance? **YES / NO**
Name of policy holder ____ Policy Holder's Date of Birth _______________________
Name of Insurance Carrier ________________________________Policy #___________________________ ID #___________________

OFFICE POLICIES, PATIENT PRIVACY AND CONSENT FORM

Welcome to our clinic. It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment.

INSURANCE INFORMATION

As a service to our patients, we can bill your insurance company on your behalf. However, as a third party, we are not always able to acquire all patient's individual policy information. Most plans only pay the base amount for services rendered. In most cases our fees may be approximately 7% to 10% higher than what your plan covers. ***Most plans due to privacy policies do not communicate with the dental offices, hence we rely on you, the policy holder, to be knowledgeable on restrictions and dollar limits within your plan and communicate that information to us.***

PAYMENT POLICY

Payment is due upon completion of treatment. Please keep in mind that it is the dentist that treats you, not your dental plan. Treatment recommendations are based on your dental health needs, which may differ from what your plan covers. Every insurance plan has its own unique "quirks" and exceptions. ***It is the patient's responsibility to cover any costs associated with dental treatments rendered which may not be covered by your dental plan.***

CONFIRMATION POLICY

When an appointment is booked, it is considered as "confirmed". As a courtesy, we contact you with a reminder prior to your appointment time. ***We kindly request that you reply to confirm that you received our reminder call or email.***

CANCELLATION/ NO SHOW POLICY

The clinic requires a minimum of 2 business days' notice if an appointment must be cancelled or rescheduled. If less than 48 hour notice is given, a penalty fee of $100 per hour will be applied. Please be aware that insurance companies do not cover missed appointment fees. When patients give advance notice of their need to cancel a scheduled appointment, this time can be allocated to those patients in need of urgent dental treatment. In this way the clinic can best serve the needs of ALL patients.

We at Third Street Dental look forward to taking care of your oral health and welcome you to our family of dental professionals. Thank You!

I have read the above policies of the Dental Clinic and understand my responsibilities as a patient. I also give permission to the Dental Clinic to Communicate, Sign and Submit required forms to my insurance company on my behalf.

_______________ ____________________________________ ______________________________

Date **Print Name** **Signature :**
Patient ( ) Parent ( ) Guardian ( )