Cottonwood Family Dental
Patient Introduction

Please email please email completed form to:
Cottonwoodfamilydental@gmail.com

First Name | Middle Name | Last Name

Social Security # | Date of Birth | Marital Status | Occupation

Email Address | Home Phone | Mobile Phone

Mailing Address | Apt # | City | State | Zip Code

Were you referred by: ❑ Friend or Family _____ ❑ Dental Insurance ❑ Internet/ Website?
Their Name

Complete if someone other than the patient is responsible

First Name | Middle Name | Last Name

Social Security # | Phone | E mail Address | Relationship to patient

Mailing Address | Apt # | City | State | Zip Code

Health Information - If yes, explain on the line below

Within the last year have there been any changes in your general health? | Yes | No

Have you ever had complications following dental treatment? | Yes | No

Are you currently under the care of a physician due to a specific condition? | Yes | No

Have you been hospitalized within the past 5 years due to surgery or illness? | Yes | No

Are you currently taking any prescription or non-prescription medications? | Yes | No

Are you allergic to any drugs, medications or latex? | Yes | No
If yes, list allergies

Do you require pre-medication prior to treatment? | Yes | No
If yes, then why?

When was your last visit to the dentist? _____

Check any of the following you have had: The following confidential information is for our records only.

- Arthritis
- Asthma
- Bleeding Problems
- Cancer
- Diabetes
- Epilepsy
- Covid 19 Vaccine
- Covid 19 Date: _____
- Heart Murmur
- Heart Problems
- Hepatitis
- Herpes
- High Blood Pressure
- HIV +
- Kidney Problems
- Low Blood Pressure
- Rheumatic Fever
- Respiratory Problems
- Stroke
- Tuberculosis
- Jaundice
- Venereal Disease
- Other _____

If any of the above are marked, please explain: _____

Female Patients Are you pregnant? _____ Due Date _____.

I hereby certify that the answers to the forgoing questions are accurate to the best of my knowledge. Since a change in my medical condition or medications I take can effect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature: _____Date: _____Relation to patient: _____

Cottonwood Family Dental
Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care. The following is a statement of our financial policy.

Payment

Please understand that payment of your **estimated** patient portion is considered part of your treatment. We ask that all patients please come prepared with any copays, deductibles,etc. as we will need to attain those before treatment is rendered.
We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. We accept the following forms of payment: Cash, AmEx. Discover, Visa,and Master Card.
2. Flexible payment plans of 6- 12 months with no interest (based on cost of treatment) upon approval with Care Credit. Approval must be received prior to treatment date.

Checks are only accepted if payment is mailed from a statement and **not** at the time of service.
Checks that are returned to our office from your financial institution are subject to a $20 return check fee.

If dentures, crowns, and/ or bridges,retainers,mouth guards or bleach trays are to be fabricated by a dental laboratory a 50% deposit will be required at the time of the first impression. The remaining balance is due before the prosthesis is cemented or delivered.

The adult that accompanies any minor to their appointment is responsible for any payment due. For unaccompanied minors, treatment will need to be pre-paid or payment sent with the minor in order for treatment to be rendered. In a divorce situation the parent or guardian who fills out the minor's paperwork will be considered financially responsible. We are unable to legally send a bill to the other party.

Insurance

As a courtesy to you we will gladly submit your insurance claims. Our responsibility is to provide you with treatment that best meets your needs. Dental insurance plans do not correspond to individual patient needs and as such, some routine and necessary dental services are not covered even though you may need those services. Your insurance company makes final determination once treatment is completed. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

Your complete insurance information needs to be presented at the time services are provided. Insurance claims cannot be backdated. If we are unable to verify dental coverage and/or insurance information is not presented at the time of your appointment, you will be required to pay our office fees at the time of service.

Appointments

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum of two business days' notice**.** Without this notice, we are unable to offer treatment times to other patients. If appointments are broken, cancelled or rescheduled without proper notice a cancellation fee of **$50** may be applied to your account and if necessary, all future appointments will require a "good faith" deposit.

Nonpayment and Past Due Accounts

I agree that I am responsible for any debt regardless of my insurance and I agree to pay my unpaid balance within 60 days of the date of service. I understand there will be an 18.5% interest charge per annum on the unpaid balance. In the event that my account is not paid as agreed, I understand that I will have to pay a collection agency fee of 40% on my unpaid balance including interest charges of 18.5% in addition to my balance. The collection agency may use any information given, including cell phone numbers to collect. In the event that it is necessary to commence legal action to collect this bill, I agree to pay all attorney fees and court costs.

Thank you for taking the time to read, understand and agree to Cottonwood Family Dental's financial agreement.

Signature of patient or responsible party: _____ Date: _____

Print Name: _____