



CREEK ROAD
DENTAL CARE

Patient Information Form

ABOUT THE PATIENT

Brian L. Homer DMD, PC
7369 Creek Road
Sandy, Utah 84093
(801) 566-5577

Patient's Name (First, Middle, Last)		Date of Birth	Social Security Number
Street Address		Home Phone	Work Phone
City, State, Zip		Mobile Phone	Daytime Phone
Age	Gender	Driver's License Number	State and Expiration
E-mail Address			

Status: Minor* Single Married Divorced Separated Widowed *If Patient is minor, please complete Section 2

Employer	Employer's Address
Occupation	
College Student	Name of School
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	

MINOR PATIENTS

Please complete if the above patient is a minor

Insured's Name (First, Middle, Last)	Employer's Address & Phone
Date of Birth	()
Social Security Number	
Spouse's Name (First, Middle, Last)	Employer's Address & Phone
Date of Birth	()
Social Security Number	

INSURANCE INFORMATION

Dental Insurance	Telephone	Insurance Address
Policy Holder	Group #	
Secondary Insurance	Telephone	Insurance Address
Policy Holder	Group #	

SPOUSAL INFORMATION

Please complete if patient is married

Spouse's Name (First, Middle, Last)	Date of Birth	Social Security Number
Status: <input type="checkbox"/> Employed* <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Stay-at-home	*Employer's Name	

ADDITIONAL INFORMATION

Nearest Relative (not residing with patient)	Relation	Telephone
Former Dentist	Reason for Leaving	
Were you referred?	<input type="checkbox"/> YES <input type="checkbox"/> NO	By whom
	<input type="checkbox"/> YES <input type="checkbox"/> NO	May we thank them?

- PLEASE CONTINUE TO BACK SIDE OF THE FORM -

FINANCIAL INFORMATION

Person responsible for this account _____
Address _____

Relationship with Patient _____
Telephone _____

Method of payment for services: Cash Credit Card Check Dental Credit Card Other Payment Type

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 3/4% per month (21% per annum) on the unpaid balance will be assessed on all accounts exceeding thirty (30) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

Any appointment missed with failure to give a minimum of 48 hours (2 days) advance notice (not on answering machine) will be charged \$60.00. A returned check fee of \$30.00 will be applied when a check does not clear the bank.

In consideration for the professional services rendered to be rendered to me (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I further agree that a waiver or breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. Collection agency fees equals 40% of the outstanding balance and will be applied when sent to them. In addition, in any month in which payments are not received, a service charge of \$15.00 will be applied. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I understand that this office has a policy to protect my individual information through careful handling of my personal information as prescribed in HIPPA laws. I acknowledge that I have been given the opportunity to review and/or receive a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent or Guardian

Date

Relationship to Patient