

PATIENT INFORMATION UPDATE

WILLIAM J FESSLER FAMILY DENTISTRY

READ AND ANSWER ENTIRE PAGE PLEASE

Patient Name _____ Birth date _____ Soc.Sec. _____

Address : _____ City _____ State _____ Zipcode _____ Occupation: _____

Cell Phone Number: _____ Email Address: _____ *May we text/email you? Y or N

Employer: _____ Phone: _____ Address _____

****Has there been a change of DENTAL Insurance Carrier? Y or N**

If YES please provide new information:

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber _____ Date of Birth _____ Soc. Sec. _____

Employer _____ Relationship to Pt _____

Insurance Company full Name _____ Ins Co. address _____

Insurance Company Phone _____

Group ID# _____ Patient ID # _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber _____ Date of Birth _____ Soc. Sec. _____

Employer _____ Relationship to Pt _____

Insurance Company full Name _____ Ins Co. address _____

Insurance Company Phone _____

Group ID# _____ Patient ID # _____

***Has there been a change in Health History since your last visit? Y / N**

If Yes please provide new information: _____

(Surgeries/replacements) _____

(Medications) _____

(Allergies) _____

***Has there been a change in Dental History since your last visit? Y / N**

If Yes please provide new information: _____

Assignment and Release

William J Fessler Family Dentistry requires payment at time of service. If you choose to discontinue care before treatment is complete, you will only be charged for care received. We submit to insurance as a courtesy. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balance not paid by your insurance at time of service. If our office is unable to collect payment from your carrier due to insufficient subscriber information, or denial of benefits, the patient is responsible for balance on account. The patient and or responsible party agree to pay INTEREST at the rate of 1 1/2% per month and all costs of collection, including reasonable attorney fees, on all amounts due on account more than 30 days from the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further hereby assign all dental benefits, to which I am entitled, including private insurance, and other health plans to William Fessler Family Dentistry. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further give permission to pull a credit report as needed, should my account be turned over to an outside source for a collection effort. A fee of \$65. is charged for patients who miss or cancel an appointment more than 1 time in a calendar year without 24 hours notice. Current Bank Fees for NSF checks will be billed to the patient for any returned checks.

(Responsible Party Signature: Patient, Parent or Guardian Signature)

(Date)

Click **SUBMIT** button to send your completed form to our office. This button only works in Acrobat.

If you are having trouble, you can send the form in an email to: admin@wfesslerdds.com