CANYON WEST DENTAL

Patient Information Form

Today's Date (MM/DD/YYYY): _____

Patient Name: First _____ Middle _____

Last _____ Nickname _____

Address: Street _____

City _____ State _____ Zip _____

Phone: Home _____Work_____Mobile _____

Email:_____

Social Security Number: _____

Date of Birth(MM/DD/YYYY): _____

Drivers License # :_____**State:** _____

Patient Employed By: _____

Occupation: _____ **Employer's Phone:** _____

Employer's Address: Street _____

City _____ State _____ Zip _____

Sex: Male Female Unspecified Prefer Not to Say

Marital Status: Married Single Divorced Separated Widowed

In case of emergency, who should be notified?

_____

Relationship to Patient: _____ **Phone**: Home _____

Work _____Mobile _____

Is the patient a Minor? Yes No

Primary Residency (If patient is a Minor): Both Parents Mom Dad Step Parent Shared Custody

Guardian

Full-time Student: Yes No

Name of School :_____

Responsible Party's Details (if applicable):

Name : First _____ Last: _____

Date of Birth(MM/DD/YYYY)**:** _____**Relationship to Patient :** Self Spouse Parent

Other_____

Dental Benefit Plan Information

Primary Dental Plan Name:_____

Phone: _____

Address: Street _____City _____

State _____ Zip _____

Name of Insured: _____Date of Birth(MM/DD/YYYY):_____

ID Number: _____

Policy Number :_____Patient Relationship to Insured :_____

Secondary Dental Plan Name: _____

Phone: _____

Address: Street _____City _____

State _____ Zip _____

Name of Insured: _____Date of Birth(MM/DD/YYYY):_____

ID Number: _____

Policy Number :_____Patient Relationship to Insured :_____

Whom may we thank for referring you?

One of our valued patients (name of patient):_____

Advertisement _____ Local Dental Society_____

Our Website Other _____

Please list other members of your immediate family who are patients in our practice:

Your financial and scheduling responsibilities with our practice. Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain..Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.
Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.
If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____

I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.
Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.
_____(initial)
I have read the above and agree to the financial and scheduling terms. _____(initial)
I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.
YES / NO (Circle One) _____(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____(initial)
I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____(initial)

Patient Signature: _____
Date of Birth(MM/DD/YYYY)**: _____**