Springbrook
FAMILY DENTISTRY

Patient Information & Financial Policies

General Information

Name: _____
Last First MI (Preferred)

☐ Male ☐ Female Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Emergency Contact Information (required by law):

Full name: _____ Relationship: _____

Phone #: _____ Email: _____

Are you okay with dogs in the space? (we have an office dog named Ollie) ☐ Yes ☐ No

How did you hear about us?

☐ Family/Friends ☐ Driving by ☐ Facebook ☐ Google ☐ Postcard ☐ Current Patient ☐ Newspaper

_____

(If someone referred you here, please enter their name so we can thank them.)

Please email a photo of the front and back of your dental insurance card to:
info@springbrookdentistry.com

Financial Policies Acknowledgement

Please initial by checking the boxes beside these statements after you have read them.

☐ I agree that Springbrook Family Dentistry, PC may communicate with me electronically at the email address I provided at patient registration.I can withdrawl my consent to electronic communications by calling 641.332.3100.

☐ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care including: diagnostic x-rays, local anesthetic, fluoride, laser, and anonymized internal research fro new care procedures.

☐ I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Springbrook Family Dentistry, PC otherwise payable to me.

☐ I understand that some treatment may not be covered by my insurance carrier. I understand that any balance of which my insurance company doesn't pay is ultimately my responsibility.

☐ I understand that cancelling my scheduled appointment less than 24 hours in advance will result in a charge of up to $50 of which I am responsible to pay.

☐ I understand that patient balances unpaid for 30 days or more will incur one or more of the following charges: Interest charges of 1.5% per month (18% APR) and legal fees for collection services.

☐ I understand that payment in full is due at the time of service unless arrangements have been made prior to the start of any treatment.

By signing below, I acknowledge that I have received a copy of the "Notice of Health Information Privacy Practices" for Springbrook Family Dentistry, PC:

_____
Parent/Guardian Signature Date: