**BRADY’S FAMILY DENTISTRY OF PLANTATION**

**4330 W. BROWARD Blvd. Suite T**

**Plantation, Florida 33317**

**Phone number: (954) 587-1800 Fax: (954) 587-6267**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDAY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE \_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CIRCLE: MINOR SINGLE MARRIED DIVORCED WIDOWED

PLEASE CIRCLE: MALE FEMALE OTHER

PATIENT’S/PARENT’S EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BUSINESS ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSES/PARENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT THIS OFFICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S/PARENT’S EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE? YES NO

NAME OF POLICY HOLDER/SUBSCRIBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER SS # OR ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S/SUBSCRIBER BIRTHDAY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMEN TIMING POLICY**

PLEASE ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TO ALLOW TIME FOR CHECK-IN ANY NECESSARY PAPERWORK.

WE OFFER A 15-MINUTE GRACE PERIOD AFTER YOUR SCHEDULED TIME.

IF YOU ARRIVE MORE THAN 15 MINUTES LATE, YOUR APPOINTMENT MAY NEED TO BE RE-SCHEDULE TO AVOID DELAYS FOR OTHER PATIENTS.

WE APPRECIATE YOUR UNDERSTANDING AND COOPERATION.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO BE SIGNED BY PARENT/GUARDIAN IF PATIENT IS UNDER THE AGE OF 18 YEARS

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Payment for services is due at the time the services are rendered; therefore, payment is expected the day of the visit. Payment is the direct obligation of the patient, or the parent if the patient is under the age of 18.

The agreement of the insurance company to pay for the dental care is a contract between you and your insurance company. Insurance is not a substitute for payment. Insurance is considered a method of reimbursement to the patient for fees owed to the doctor. Please understand that insurance companies allow payment of services rendered based on the amount they consider reasonable and customary for a particular area. Under most circumstances, insurance fee schedules bear no relationship to today’s standards, quality, and cost of care. We will be happy to extend a courtesy in filing the insurance claims; however, all charges are your responsibility from the date the services are rendered.

Some insurance companies issue checks directly to the patient, we will verify this matter at the time you select our services. If this is the case, we will require the patient to pay for services rendered upfront and your reimbursement will come from the insurance company. We will kindly help you to file the insurance claim.

**We reserve the right to charge for a NO SHOW or CANCELLED appointment if it is done on the same day of the scheduled appointment.** **This charge will be for $50.00 per incident.** We request a 24 hour notice for a cancellation or change to an appointment.

If it becomes necessary to place this account into collections, I understand that I will be responsible for any and all collection fees.

We will be glad to accommodate your financial responsibilities (insurance co-pay, and/or deductibles if applicable) by accepting the following methods of payment:

* **Cash**
* **Check (Valid identification required)**
* **MasterCard**
* **Visa**
* **Discover**
* **CareCredit**

**Please provide us with the Pharmacy you use, and its location. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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By “Opting In” to or using a “text Message Service” (as defined below) from Brady’s Family Dentistry of Plantation you accept these terms and conditions.

This agreement is between you and Brady’s Family Dentistry.

“Opting In,” “Opt In” refer to requesting, joining, agreeing to, enrolling in, signing up for, acknowledging, responding to, or otherwise consenting to receive one or more Text Messages.

“Text Message Service” includes any arrangement or situation in which we send one or more messages addressed to your Mobile phone number, including text messages (such as SIMS, MMS, or successor protocols or technologies)

By consenting to receive text messages from us, you agreed to these Text Messaging Terms & Conditions.

Thank you,

Brady’s Family Dentistry.

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_