New Patient Information

WILMINGTON PERIODONTICS & IMPLANT CENTER

Date: _____

Patient Information

Name: _____ Gender: M / F
Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
Driver's License Number: _____ Marital status: M☐ed/ W☐wed/S☐le
Address: _____
City: _____State: _____Zip: _____
E-mail Address: _____
Home Number: _____ Work Number: _____
Mobile Number: _____ Other Number: _____

Occupation: _____
Name of Employer: _____

Guarantor of Account (if other than the patient)

Name: _____ Gender: M / F
Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
Driver's License Number: _____ ☐ ☐ ☐
Address: _____
City: _____State: _____Zip: _____
E-mail Address: _____
Home Number: _____ Work Number: _____
Mobile Number: _____ Other Number: _____

Name of Employer: _____

Dental Insurance Information

Policy Holder's Name: _____Member ID if Not SS#_____
Relationship to Patient: Self/Spouse/Child/Other Date of Birth:_____
Insurance Company Name: _____
Claims Address: _____
City: _____State: _____Zip: _____
Group Number: _____ Policy Number: _____
Company Phone Number: _____ Payor ID #: _____

Henry M. Best, DDS
Office: 910.772.9770

Lance H. Hutchens, DDS, MS, PA
1611 Doctors Circle, Wilmington NC 28401

Jeffery R. Thomas, DDS
Fax: 910.772.1553

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PERIODONTICS &
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Financial Responsibility **Date: _____**

Thank you for choosing us as your oral health care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

Payment: Fees for services are due when treatment is rendered. Payment may be made in cash, check, or by credit card.

Insurance: If you have dental insurance, we will file the appropriate claim forms with your insurance company, provided you supply us with documented evidence of coverage. Please understand that insurance is filed as a courtesy and the amount of reimbursement is determined by the insurance carrier. It is not the policy of the office to enter into any dispute between you and your dental insurance company.

Third Party Payment: If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.

Non-Payment: In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

Returned Checks: A $25 processing fee will be charged for a returned check.

Cancellation: Your time is very important to us, and we strive to provide all of our patients with the best possible care. When an appointment is scheduled, that time has been reserved exclusively for you and when it is missed, that time cannot be used to treat another patient. In order for us to ensure this high level of service, we ask all of our patients to notify the office at least 48 hours in advance if they cannot keep the appointment. Our time is highly requested and we want to ensure that our patients do not have to wait for months at a time to receive care. It is for this reason that we have a cancellation policy that we ask you to honor. We respect and value your time and we ask that you do the same of ours. Depending on the procedure you have scheduled at our office, the guidelines can differ. However, the only rule we have is: **Please give us a minimum of 48 hour's notice to cancel you appointment to avoid a $50.00 fee.** If you have any questions regarding the cancellation policy please contact our office and ask to speak with one of our patient care coordinators.

Financial Responsibility Agreement
I have read and understood the Financial Responsibility policies as outlined above. I agree to the terms and accept full responsibility for all charges and services rendered.

Patient or Authorized Representative Signature: _____
Relationship to Patient: _____ Date: _____

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