WEST 85TH DENTAL FINANCIAL AGREEMENT

PLEASE INITIAL BY EACH BOX TO INDICATE YOU HAVE READ THESE POLICIES.

Due to recent legislation, you are covered under the privacy act; your information through your insurance provider is confidential and therefore will not be release to our office. We urge **YOU** to become familiar with any dental benefits you may have. The office will ***not*** *be pre-determining your basic dentistry*. If you or your insurance company requires pre-authorization, we will be happy to provide you with the information, with the results only coming directly to you. Ultimately if there is a problem with your insurance, it is your responsibility.

PLEASE CHOOSE: OPTION 1 OR OPTION 2

Option 1 Non Assignment (Non Direct Billing)

- All accounts are paid in full by you at the time of service. The insurance claim is sent off Electronically by our office at the time of the appointment. The insurance will reimburse you In as little as 3 days, if you have direct deposit with your insurance carrier, or within a week If receiving cheques from your insurance provider

Option 2 Assignment (Direct Billing)

- West 85th Dental will accept direct payment from your insurance company, leaving you to pay to the remaining difference, after we have sent off the claim electronically to your insurance carrier. In order for our office to do this we require the following:

  Any portion not covered by insurance must be paid at time of service
  Patients are responsible for any outstanding balances after insurance has paid
  We require a **Valid Credit Card on File**

I authorize West 85th Dental to place through any outstanding balance automatically on my Credit card:

VISA: _____-_____-_____-_____ EXPIRY DATE: ___-___ CVI: ____

M C : _____-_____-_____-_____EXPIRY DATE: ___-___ CVI: ____

If you have two insurance plans, we will take the primary with the secondary insurance payment going to you directly, therefore you will be paying the difference from primary to secondary.
The secondary insurance plan payment goes directly to you. We will be happy to do the paperwork for you. If we are required to send off a manual claim to your insurance company, we require a signature on file. Please be aware that we do not hold claims after 45 days.

LATE OR MISSED APPOINTMENT FEE

- We do our best to respect our patient's time and in turn ask for the same courtesy. Therefore our office requires 48hours – 2 business days to change or reschedule a scheduled appointment. If we are not provided with such notice, a fee of be charged. This fee must be paid prior to any further appointments.

SIGNATURE: _____ DATE: _____

WEST 85TH DENTAL MEDICAL INFORMATION

PLEASE INDICATE BY CIRCLING IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

Allergy	Head Injury	Radiation Treatment
Anemia	Heart Disease	Respiratory Problems
Arthritis	Heart Murmur	Rheumatic Fever
Artificial Joints	Hepatitis	Sinus Problems
Asthma	HIV & AIDS	Stroke
Birth Control Pill	High Blood Pressure	Sleep Apnea
Blood Disease	Jaundice	Snoring
Cancer	Kidney Disease	Thyroid Disease
Diabetes	Liver Disease	TMJ
Dizziness/Fainting	Low Blood Pressure	Tobacco Use
Epilepsy	Multiple Sclerosis	Tuberculosis
Excessive Bleeding	Pacemaker	E-Cigarettes

What medications are you **ALLERGIC** to: Please list all: _____

_____

What medications and vitamins are you currently taking: Please list all: _____

_____

Do you require **Pre Medication** for Dental Treatment: Yes: ☐ No: ☐

Women Only: Are you Pregnant: Yes ☐ No ☐ If yes, when is the due date: _____

Do you like the **shade** of your teeth: Yes ☐ No ☐

AUTHORIZATIONS:

I AFFIRM THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE.
This information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my Medical status. I authorize the dental team to perform the necessary dental services that I may require.

SIGNATURE: _____ DATE: _____

WEST 85TH DENTAL NEW PATIENT INFORMATION

Name:_____ Preferred Name:_____
FIRST NAME LAST NAME
Male☐ Female☐ DOB:_____ Single☐ Married☐ Divorced☐ Widowed☐
Day Month Year

Home Address:_____
Number Street City Postal Code

Phone Numbers: Home:_____ Cell: _____ Work:_____

EMAIL ADDRESS: REQUIRED:_____ Drivers Licence:_____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: _____ Relationship to: _____ Phone Number:_____
First Name Last Name
Employer: _____ Phone Number _____

Billing Address if Different from Above:_____
Street City Postal Code

PRIMARY INSURANCE INFORMATION

Insured's Name:_____ DOB:_____ Name of Employer:_____
First Name Last Name Day Month Year

Insurance Carrier Name:_____ Group Policy Number:_____ ID Number:_____

Coverage % :_____ Deductable_____ Yearly Limit $ _____ Renewal Date:_____

Secondary Insurance Information

Insured's Name:_____ DOB:_____ Name of Employer:_____
First Name Last Name Day Month Year

Insurance Carrier Name:_____ Group Policy Number:_____ ID Number:_____

Coverage % :_____ Deductable_____ Yearly Limit $ _____ Renewal Date:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

Please Check One: Mail Outs☐ Internet☐ Facebook☐ Walk Ins☐ Radio☐
Referral_____