Hancock Dentistry, PLLC

3829 Cleghorn Ave. • Nashville, TN 37215 (615)383-0132

Patient Information

Chart#:

FOR OFFICE USE ONLY

Patient Name: Last First MI

Preferred Name

Title: **Gender:** Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone: Home Mobile Work Ext

Fax Other

Address:

Address 1

Address 2

City State Zip Code

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work

☐ Other (name below):

Name of person, office, or other source referring you to our practice:

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI)

_____ (Preferred Name)

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Email Address: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

Best time to call: _____

Address: _____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____ (Address 1)

_____ (Address 2)

_____ (City)

_____ (State) _____-_____ (Zip Code)

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ _____

Date

Relationship to Patient:

Response Date: _____