Welcome

To the office of
L. Cory Evans, D.M.D.

Family Last Name ______________________ Date ____________

Who may we thank for referring you to our office? ______________________

Responsible Party for Account

Name ____

Male/Female Single/Married/Divorced/Other

Birth Date__________________ SS# ________- _____ - _______

Address____

City _________________________ State______ Zip __________

Home _____________ - _____________ - ______________

Work _____________ - _____________ - ______________

Cell _____________ - _____________ - ______________

Email ____

Best time/place to reach you? ____________________________

Employer ____

Occupation ____

Employer Address ______________________________________

Spouse or Other Parent of Children

Name ____

Male/Female Single/Married/Divorced/Other

Birth Date__________________ SS# ________- _____ - _______

Address____

City _________________________ State______ Zip _________

Home _____________ - _____________ - ______________

Work _____________ - _____________ - ______________

Cell _____________ - _____________ - ______________

Email ____

Best time/place to reach you? ____________________________

Employer ____

Occupation ____

Employer Address ______________________________________

Please list dependant children

Child's Name	Birth Date
__________________________	___________________
__________________________	___________________
__________________________	___________________
__________________________	___________________
__________________________	___________________

Emergency Information

Other than immediate family

Name ____

Relationship ____

Phone _____________ - _____________ - ______________

Name ____

Relationship ____

Phone _____________ - _____________ - ______________

I understand the following Financial Policy:

- When canceling a scheduled appointment, I will give 24 hours advanced notice or I will be charged a $50.00 fee.
- I will be charged $20.00 for any returned checks.
- Accounts unpaid over 90 days accrue interest of 1.5% per month (18% per year) until paid in full.
- I agree to pay all costs of collection including a 50% collection agency commission.
- I agree to pay all attorneys' fees and submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

Uninsured Patients: All visits are to be paid in full at the time of service. 5% will be deducted if charges are paid in full by **cash** or **check** at the time of service

Insured Patients: See additional policies on the reverse side of this form

I hereby authorize Dr. L. Cory Evans to perform any or all forms of treatment, medication and therapy that may be indicated in connection with dental care of the patients above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. However **this does not include insurance coverage benefits**. A photocopy of this assignment will be used for each family member and will be considered as valid as an original.

Signature of Responsible Party ____ **Date** ______________

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE REVERSE SIDE.

Insurance Information

Each patient is responsible to provide complete and accurate insurance information. It is the patient's responsibility to verify insurance coverage. You must know the benefits of your plan, waiting periods and any frequency restrictions. Please advise us immediately of any changes in your coverage.

Primary Insurance

Subscriber's Name ___________________________________

Insurance Company ___________________________________

Subscriber's ID # ___________________________________

Group # ___________________________________

Insurance Phone # ___________ - ___________ - __________

Insurance Address ___________________________________

City ____________________ State _______ Zip ___________

Secondary Insurance

Subscriber's Name ___________________________________

Insurance Company ___________________________________

Subscriber's ID # ___________________________________

Group # ___________________________________

Insurance Phone # ___________ - ___________ - __________

Insurance Address ___________________________________

City ____________________ State _______ Zip ___________

I understand this additional Financial Policy regarding insured patients:

- Hygiene visits require a $20.00 payment per person at the time of service or as account history dictates.
- All other visits require a $50.00 payment at the time of service, which will be applied to my portion of services.
- My dental insurance carrier may pay less than the actual bill for services.
- In some cases insurance companies send payments directly to the subscriber. If it is determined my insurance will remit payments to me, I will pay Dr. Evans **in full** at the time services are rendered to my family or myself. If I pay by **cash** or **check**, I will be given an allowance of 5% from my total balance.
- I am financially responsible for all charges whether paid or not paid by said insurance.

I hereby authorize Dr. Evans to release all information necessary to secure the payment. I authorize disclosure of my or my family member's dental records to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize and hereby request my insurance company to pay directly to Dr. Evans insurance benefits otherwise payable to me. A photocopy of this assignment will be considered as valid as the original.

Signature of Responsible Party for Family ______________________________ Date ____________