824 W. Lamar Alexander Pkwy. • Maryville, TN 37801 • 865.379.7004
www.BlueRidgeDentistryOnline.com ♦ info@blueridgedentistryonline.com

Patient Information

Today's Date ______________________

Patient Name: ______________________________ ________________________________ _____ ___________________
Last First MI Preferred

Gender: ☐ Male ☐ Female **Status**: ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth ____/____/_____ **SSN#** ___________________ **Email**: ____

Address: ____ ___________________________ _______ __________
Street City St Zip Code

Phone: (____)________________ (____)_________________ (_____)________________ (_____)__________________
Home Mobile Work Other

Spouse or Guardian Information (if applicable)

Name: ____ ____________________________________ ______
Last First MI

Date of Birth: _____/_____/______ **SSN**: ___________________ **Employer Name**: ____________________________

Address: ____ ___________________________ _______ __________
Street City St Zip Code

Phone: (_____)_______________ **Cell**: (_____)______________ **Work**: (_____)_________________ **ext**: ____________

Primary Dental Insurance Information

Insurance Company: ____________________________ **Insured's Employer Name**: ________________________________

Employer Address: ____________________________________ ___________________________ _______ _________
Street City St Zip Code

Name of Insured: ____________________________________ __________________________ _____
Last First MI

Insured's Date of Birth: _____/_____/_______ **Member ID #** ____________________ **SSN** ________________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address: ____ ___________________________ _______ _________
of insured Street City St Zip Code

Name of person filling out this form: _________________________________ ____________________________________
Printed Name Signature

Relationship to patient: ☐ Self ☐ Other (describe):____

Requested Additional Information

☐ Check here if you have additional **Dental Insurance**. A supplemental insurance form will be provided for your convenience.

☐ Check here if we need to submit a **Records Request** to your former dentist. A form will be provided for your convenience.

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Financially Responsible Party *(Patient must sign if over 18 years old)* ☐ Check if this information is different from the insured

Name: ______________________________ (Last) ______________________________ (First) ______ (MI)

Gender: ☐ Male ☐ Female **Status**: ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: _____/_____/________ **SSN**: _______________________

Phone: (_____)_______________ **Cell**: (_____)_____________ **Work**: (_____)________________ **ext**: ___________

Address: ______________________________ (Street) ______________________ (City) ________ (St) __________ (Zip Code)

Employer Name: ____ **Phone**: ______________________________

Consent for Services & Financial Policy

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 will be determined before treatment, and that amount is due at the time of 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 agree that it is the patient's personal responsibility to pay for all dental services rendered. As a matter of convenience to the patient, the dental office will prepare and submit the necessary insurance forms and use reasonable efforts to collect from the patient's dental insurance carrier the benefits which are extended to the patient. All credits received will be applied to the patient's account. However, the patient understands and agrees that the dental office cannot do more than submit insurance claim forms and credit any payments received. The contract of insurance is between the patient and the patient's dental insurance company. If the dental insurance company pays nothing, or pays less than what the patient anticipated, the patient understands and agrees that it is the patient's responsibility to pay the balance owed. Further, the patient understands and agrees that any estimate of any benefit that may be paid by the patient's dental insurance company is purely an estimate and that the amount of any credit that will be ultimately applied will be the actual amount paid. Treatment estimates are based on applicable contracted insurance fee schedules. When insurance payment is denied due to plan limitations or exclusions, or when coverage is terminated, these denied charges will revert to Blue Ridge Family Dentistry's Usual and Customary Fees, and the patient is responsible for all applicable costs incurred. It is the patient's responsibility to keep scheduled appointments. Failure to show for an appointment or to notify Blue Ridge Family Dentistry of a cancelled appointment within 24 hours of the time allotted may incur a cancellation charge.

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 legal & collection fees.

I also am giving consent to Blue Ridge Family Dentistry and staff to examine and treat my dental needs as deemed necessary.

I have read and fully understand the conditions of treatment and my personal financial responsibility and by signing herein below agree to those terms. In the event that I am not the patient, I agree to said terms on behalf of the patient as the patient's parent or legal guardian.

Authorization & HIPAA Release

I hereby certify that I have read and understand the previous information, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize Blue Ridge Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

List of additional names we can release information to:____

____

Signature of PATIENT, parent or guardian (Responsible Party):____

Printed Name of Responsible Party: ______________________________________ **Date**: ___________________

Relationship to Patient: ______________________________ **Patient's Name:** ______________________________