WELCOME TO THE DENTAL OFFICE OF DR. JACK B. SHARE

Thank you for selecting our office for dental health care. We will strive to provide you with the best possible care and service. Please help us meet your needs by completely filling out this form to the best of your ability. If you need assistance, we will be happy to help. All information is confidential.

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Home Address _____ City _____ State _____ ZIP _____
Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____ Email _____@____
Date of Birth / / Social Security Number - - Dental Insurance: Y N
Please Circle: MALE FEMALE MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

DENTAL INSURANCE INFORMATION

Relationship of patient to insured: SELF SPOUSE MINOR OTHER
Insured's Group Number _____ Insured's Name _____
Insured's ID Number _____Insured's Date of Birth / /
Insured's Employer's Name _____ Insured's Employer's Address _____
City_____ State _____ ZIP_____ Insurance Carrier _____
Insurance Carrier's Address _____ City _____ State _____ ZIP_____
Phone ( ) _____ Do you have any additional secondary dental insurance? If so, what is the carrier's name
_____ Group Number_____ Policy ID Number _____
Address_____ City_____ State _____ ZIP_____

GETTING TO KNOW YOU

Are there any family members, friends or colleagues that are also patients?_____
Relationship to you _____
Who referred you to our office? _____
What is your occupation?_____
Who is the person to contact in the event of an emergency? _____Phone ( )_____

OUR OFFICE AND INSURANCE POLICIES AND YOUR FINANCIAL RESPONSIBILITIES

- Patients <u>with</u> dental insurance: We will submit your claims for processing as a courtesy but make no guarantees of coverage and do our best to obtain maximum benefits. Should coverage be less than estimated or if maximum benefit are exceeded, the balance will be your responsibility. It is also your responsibility to pay in full at the time of service any deductible, co-payment or any other balance not paid or covered by your insurance.
- We participate with Delta Dental Premier and BlueCross/BlueShield Dental Blue Indemnity and accept all forms of insurance that allow us to bill the patient for any and all uncovered services.
- Patients <u>without</u> dental insurance: You are requested to pay in full at the time of service.
- If payment in full can not be made at the time of service, payment arrangements <u>must</u> be made with the receptionist.
- We offer the following methods of payment: Cash, Personal Check, MasterCard, VISA, AMEX and Discover.
- Please request a personal copy of Our Financial Policy at the front desk, also available at ShareThatSmile.com.
- We reserve the right to charge your account, if we are not notified of an appointment change within 24 hours. Late arrivals in excess of 15 minutes may be asked to reschedule. Your understanding is appreciated.
- Please be aware that a Health Protection & Safety Fee is entered for every patient visit.
- I have read, thoroughly understand the office policies and fully agree to my financial responsibilities.

SIGNATURE _____ DATE _____