OAK HILL DENTAL GROUP, 272 SW BENTLEY PLACE, LAKE CITY, FLORIDA 32025

Welcome to our practice. We are pleased to provide you with the best possible dental care. If you have any questions or need assistance in completing this form , we will be happy to help you. This information is confidential and will only be used to treat you and assist you with insurance or payment. If you are a current patient, thank you for updating your information.

Patient name _____ Date _____

Date of Birth _____
Home Phone _____ Work Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Social Security Number _____ Please Select *Male* ☐ *Female* ☐
Driver's License Number _____
Occupation _____ Employer _____
If Student, Name of School _____
Marital Status Divorced
If married, spouse's name _____
Spouse's Employer _____
Person to Contact in Case of Emergency: Name _____ phone _____
Whom may we thank for referring you? Name _____
Who is responsible for this account? _____
Relationship to patient _____
Do you have dental insurance? _____yes _____no
Insured Employer _____
Insured Social Security Number _____
Birth date of insured (M/D/Y) ___ / ___ / ___
If so, please provide your insurance card. It will have the additional information needed to file claims.
Do you have additional dental insurance? ◯ yes ◯ no
If so, please provide that insurance card and we may need more information.
We accept CASH, CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.
(Care credit is a credit line to cover dental expenses. It is 6 or 12 months without interest if you qualify. Just ask for a brochure. The approval process takes just a few minutes on the phone or online)

I certify that I have read and understand the above information to the best of my knowledge. The above questions and the questions pertaining to my medical and dental history have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient _____

OAK HILL DENTAL GROUP, 272 SW BENTLEY PLACE, LAKE CITY, FLORIDA 32025

Patient name _____ **Date** _____

Insurance Policy

I acknowledge that the total fees for dental treatment will be submitted to my insurance company by Oak Hill Dental Group. It is understood that my portion of the charges as presented to me are only an estimate based on previous experiences with my insurance company. If for any reason payment from my insurance company does not satisfy the expected benefit, then I will be responsible for payment in full to Oak Hill Dental Group. This payment is due when treatment is rendered, unless other arrangements have been made.

Check Writing Policy

When you pay by check, you expressly authorize Oak Hill Dental Group, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of $25 (or legal limit) plus any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

I understand the check policy. I understand that I must provide a photo ID such as a driver's license.

Confirmation and Missed Appointments

As a courtesy reminder, we try to confirm all appointments. There may be times that we ask you to call us back with a confirmation call.

HOW SHOULD WE CONTACT YOU TO CONFIRM YOUR APPOINTMENTS?
(CIRCLE THE ONE YOU PREFER)

TEXT (_____) _____-_____

CALL (_____) _____-_____

EMAIL: _____@_____

THERE IS A $25 CHARGE FOR A MISSED VISIT OR VISIT CANCELLED WITHIN A 24 HOUR NOTICE.

I understand the Insurance, Check Writing, and Missed/confirmation Appointment policies.

Signature _____ **Date** _____

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Patient (child's) name _____ Date _____
Father's name _____ Mother's name _____
Date of Birth _____ Who does child live with? _____
Social Security Number _____ Please Select *Male* ☐ *Female* ☐
Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Name of School _____
Person to Contact in Case of Emergency:Name _____ phone _____
#2 Person to Contact in Case of Emergency:Name _____ phone _____
Whom may we thank for referring you? Name _____
Who is responsible for this account? _____
Relationship to patient _____
Do you have dental insurance? _____yes _____no
Insured Employer _____
Insured Social Security Number _____
Birth date of insured (M/D/Y) ___ / ___ / ___
If so, please provide your insurance card. It will have the additional information needed to file claims.
Do you have additional dental insurance? yes ◯ no ◉
If so, please provide that insurance card and we may need more information.

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Signature of parent _____

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