OLDROYD FAMILY DENTISTRY

Today's Date: _____

ABOUT YOU

Name: _____ Preferred Name: _____

Date of Birth: ____-____-____ Age: _____ M F

Address: _____Apt.#_____ City: _____State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

E-mail: _____

Preferred method of contact for appointment confirmation (circle): Call Text E-mail

Employer: _____ Occupation: _____

Last Dental Visit: _____ Last teeth cleaning? _____

How did you hear about us? _____

Reason for today's visit? _____

EMERGENCY INFORMATION

Person to contact/Relationship: _____ Phone Number: _____

INSURANCE INFORMATION/ FINANCIAL POLICY

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber DOB: ___/___/___ Subscriber ID/SSN: _____-_____-_____Subscriber Employer: _____

Insurance company: _____ Group #: _____

*Payment is expected at time of service. We do accept insurance assignment but the patient portion is due at each visit. We do not send monthly bills. While we are contracted with several insurance companies, we accept all insurances as an out-of-network provider. Ultimately, you are responsible for payment of all fees for dental care rendered by our office.

METHODS OF PAYMENT (please circle one)

Cash Check Credit Card Care Credit Citi Health Card

OFFICE POLICY- BROKEN APPOINTMENTS AND CANCELLATIONS

At Oldroyd Family Dentistry we schedule our patients for treatment exclusively with the doctor or hygienist at a certain time and therefore ask that you be on time for your appointments. We will make every effort to contact you the day before your appointment as a reminder, but we often must leave you a message. There will be a $35 charge for cancellations and broken appointments with less than 24 hours notice.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I have read and understand the financial policy and office policy. Should further information be needed you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ _____

Signature of Patient, Parent or Guardian Date