Bucktown Dental Care

Family & Cosmetic Dentistry

Get-Acquainted Questionnaire

In order for us to better serve you, it is requested that you fill in the following information.

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

If Patient is a Minor, give Parent's or Guardian's Name _____

Has any member of your family been treated in our office? If yes, please give name _____

Who May We Thank For Referring You to our Office? _____ TODAY'S DATE _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ DR. LIC # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

SPOUSE'S NAME Last _____ First _____ Middle _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOCIAL SECURITY # _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION
Name, Address & Telephone of a Relative Not Living with You _____

DENTAL INSURANCE INFORMATION

Insured's Name _____

Insurance Co. **(Primary)** _____

Insurance Co. **(Secondary)** _____

Insured's Employer _____

Insured's Soc. Sec. # _____

Group # _____ Phone # _____

Your dental insurance is your responsibility...BUT WE CAN HELP... Regardless of what we might calculate as your dental benefits in dollars, we must stress the fact that you, the patient, are responsible for the **TOTAL TREATMENT FEE.** As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expenditures. Any estimate is based on limited information obtained from your insurance company. **We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company pays its claims.** We allow 45 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

METHODS OF PAYMENT

Cash, Check, or Credit Card

Please check one of the following:

☐ Payment in full at each appointment.

☐ Payment of non-insurance portion at each appointment.

We do no billing. All balances must be paid in full at the time of service. Billing charge: If I do not pay the entire New Balance after 30 days a $6.00 monthly billing charge will be added to the account. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

EMAIL: _____ CELL PHONE: _____

AUTHORIZATION

I hereby authorize payment directly to BUCKTOWN DENTAL CARE of group insurance benefits otherwise payable to me. I understand that **I am responsible for all cost of dental treatment.** I hereby authorize BUCKTOWN DENTAL CARE to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on the next page) are true and correct to the best of my knowledge. **If I have any changes in my health, I will inform my dentist.**

SIGNATURE OF RESPONSIBLE PARTY

X _____ DATE _____

☐ Adult Patient ☐ Father (Husband) ☐ Mother (Wife) ☐ Guardian