WESTBERRY DENTAL

RICHARD S. WESTBERRY, D.M.D.

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Date_____

PATIENT INFORMATION

Name _____

Please circle one: Mr. Mrs. Ms Miss Dr.

Please circle one: Married Single Child E-Mail _____

Address_____City _____State_____Zip _____

Home Phone _____ Work Phone_____ Cell_____

Social Security # _____Driver's License #_____Birthdate_____

Employer _____

Employer's Address _____City _____State_____Zip _____

Spouse or Parent's Name _____

Whom May We Thank For Referring You_____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____Relation to Patient_____

Birthdate _____Subscriber's Social Security No._____

Name of Employer_____Phone No. _____

Insurance Company _____Group No._____

Insurance Company Address_____

City _____State _____Zip _____

How much is your deductible?_____Max. Annual Benefit_____

OFFICE FINANCIAL POLICY

So that we may avoid any misunderstanding and possible embarrassment to all concerned, we have formulated this office policy to inform all patients of our position regarding finances. We encourage any questions you might have regarding fee or any other aspect of your care as our patient.

1. Payment is due at the time the service is rendered.
2. Any exception to the above must be approved prior to treatment and definite arrangements made for payment.
3. We will be glad to discuss fees in advance, if you so desire, with the understanding that the fee quoted is an average and may be slightly higher or lower, depending upon the degree and extent of the procedure involved.
4. INSURANCE CLAIMS: Please realize that our services are provided to our patients, NOT to insurance companies. In all but a few exceptions, we must insist that payments be made by the patient and any reimbursement be made to the patient by the INSURANCE COMPANY. Insurance estimates are exactly that. The insurance company may pay more or less than what we estimate. THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE NOT PAID BY THE INSURANCE COMPANY
5. I hereby acknowledge that if my account becomes seriously delinquent, it will be sent to a collections agency. I agree to reimburse you the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts.
6. Interest of 1.5% per month (18% apr) will be charged on all delinquent accounts.
7. There may be a charge for missed appointments or appointments cancelled with less than 24 hours notice.

MEDICAL HISTORY

Physician's Name _____ Phone _____

Please list any medications you are now taking _____

_____

Please list any allergies to medications or substances _____

_____

Do you have or have you had any of the following? Please circle "yes" or "no"

A.I.D.S./H.I.V. Positive	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Chemotherapy	Yes	No
Diabetes	Yes	No
Drug Dependency	Yes	No
Epilepsy/Seizures	Yes	No
Excessive Bleeding	Yes	No
Heart (Attack, Disease, Surgery)	Yes	No
Hepatitis A, B, C	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Latex Allergy	Yes	No
Liver Disease	Yes	No
Osteoporosis	Yes	No
Have you ever had or ever taken medicine for osteoporosis	Yes	No
Stroke	Yes	No
Tobacco Use	Yes	No
Tuberculosis	Yes	No

Please list any disease or condition that you have or have had that's not listed above: _____

WOMEN

Are You: Pregnant? Yes _____ Months No Nursing? Yes No Taking birth control pills? Yes No

AUTHORIZATION AND RELEASE

I understand that the routine use of local anesthetic involves a certain risk and I accept that risk. I will specifically request no anesthetic if that is my preference.

I certify that I have read and understand the above information to the best of my knowledge. The above questions 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 to all services rendered on my behalf or my dependents. I have read and agree to the OFFICE FINANCIAL POLICY as stated on the reverse of this page.

X _____

Signature of patient (or parent if minor)

R.C. Westberry D.M.D.
3120 S. Ridgewood Ave
S. Daytona, FL 32119

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that this office is compliant with the HIPAA Privacy Practices.

PLEASE PRINT NAME

SIGNATURE

DATE

It is okay to leave detailed messages on my answering machine. Yes No _____
Initial

FINANCIAL POLICY

- Payment is expected at time of service.
- If you require financing, we have several options; these arrangements need to be made prior to treatment.

MISSED APPOINTMENT POLICY

- I hereby acknowledge that I may be charged a non-refundable fee of $25 for a missed appointment.
- A missed appointment occurs when the patient fails to notify this office of cancellation 24 hours prior to the reserved appointment time. I acknowledge that if I miss several appointments, I may be required to pre-pay for my next appointment, or be placed on a will-call list. (Will-call refers to a list of patients who are called when last minute openings occur in the schedule.)

COLLECTIONS POLICY

- I hereby acknowledge that if my account becomes seriously delinquent, it will be sent to a collections agency. I agree to reimburse you the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts.

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

- Our Doctor is here to provide you with the best dental care. His primary concern is your well being, not your insurance. Therefore, it is the patient's responsibility to be aware of what their policy covers.
- It is very important for you to read your insurance policy very carefully. As we file claims with numerous insurance companies and each company has many different plans, we can not possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy and you will be responsible for any part of the fee that is not covered under your policy. It is very important that you are familiar with the benefits, coverage and policies of your insurance plan.

I have read the above and understand your policy on missed appointments, collections and that I am responsible for knowing the coverage and benefits of my insurance policy.

_____ _____

Patient Signature Date