Appleway Dental Clinics ~ Welcome to our Office ~ Confidential Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: M / F Martial Status Married / Single / Child / Other

Birth Date:(dd/mm/yr)_____/_____/ _____ **Email Address**: _____

Phone (Home):_____ (Cell): _____ (Work): _____ Ext: _____

Address: _____
Street/Box # City Prov. Postal Code

Emergency Contact: _____ _____Phone: _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient?
☐ Yes ☐ No

Insurance Plan Name:_____

Insured's Birth Date: _____

Insurance Plan Name and Address:_
_____

ID #: _____ Group #: _____

Secondary

Name of Insured:_____ is insured a patient?
☐ Yes ☐ No

Insurance Plan Name:_____

Insured's Birth Date: _____

Insurance Plan Name and Address:
_____

ID #: _____ Group #: _____

Referral Information

Whom may we thank for your referral? **(CHECK OFF) Yellow pages____ Google____ Advertisement/Newspaper____**
Mailing____ Another Appleway location: STETTLER____VILLAGE____HILLTOP___ I live in area____
OR Patient Name: _____ ***Referrals are our greatest compliment!*** ☺

Financial & Insurance Agreement

Payment **in full** is due at the time of treatment and is considered a part of your commitment to this office. For extensive treatment plans we may be able to offer small in house payment plans with written approval from the clinic and arranged ***prior*** to your treatment appointment date. We will gladly file dental claims on your behalf, but we are not a party to any insurance programs or contracts. If you have any questions regarding your insurance we recommend that you contact your dental insurance plan directly. It is important that you be familiar with your benefits to eliminate any disappointments with coverage and reimbursement. Your benefit coverage is a contract between yourself, your employer and the insurance company. Per the Privacy Act, your dental plan information is considered "*confidential medical information*" and as such it will not be released to us, as your dental care provider.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Initials_____

Appointment Policy

In order to be fair to both our team members and to all of our patients, we do require that you notify our office with at least two business days (48 HOURS) notice for any appointment changes or cancellations. Failure to provide this notice will result in a $60.00 / hour missed appointment charge.

Initials _____

Consent for Treatment/Services

I have read the above policies of Appleway Dental Clinics and I acknowledge consent for treatment. I agree to pay for all services rendered.

_____ Printed Name _____
Signature of Patient, Parent