SYMMETRY DENTAL PATIENT INFORMATION

NAME:_____Preferred Name_____
First Name **Last Name**

Male___ Female___ DOB _____ Single__Married__Divorced__Widowed_____
Day Month Year

Home Address:_____
Street City Postal Code

Phone Numbers: Home:_____Cell:_____Work:_____

Email Address: _____
REQUIRED

Drivers Licence: _____Employer:_____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name:_____Relation to _____Phone Number_____
First Name Last name

Employer_____ Phone Number_____

Billing Address if Different from Above_____
Street City Postal Code

PRIMARY INSURANCE INFORMATION

Insured`s Name:_____DOB:_____Name of Company:_____
First Name Last Name Day Month Year Employer Name

Insurance Carrier Name:_____Group Policy Number_____ID Number_____

Coverage %:_____Deductible_____Yearly Limit $_____ Renewal Date_____

SECONDARY INSURANCE INFORMATION

Insured`s Name:_____DOB:_____Name of Company:_____
First Name Last Name Day Month Year Employer Name

Insurance Carrier Name:_____Group Policy Number_____ID Number_____

Coverage %:_____Deductible_____Yearly Limit $_____ Renewal Date_____

Please choose an option for appointment confirmations: E-mail ☐ Text ☐ or BOTH ☐ Phone Only ☐

SYMMETRY DENTAL FINANCIAL INFORMATION

We urge you to become ***familiar with any dental benefits you may have***. The office will **not** *be pre-determining your basic dentistry*. If you or your insurance company requires pre-authorization for basic, we will be happy to provide you with the information and with the results only coming to you directly. Ultimately if there is a problem with your insurance, it is your responsibility.

PLEASE CHOOSE: OPTION 1 OR OPTION 2

Option 1 Non-Assignment (Non-Direct Billing)

- ☐ All accounts are paid in full by you at the time of service. The insurance claim is sent off electronically by our office at the time of the appointment. The insurance will reimburse in as little as three days if you have direct deposit with your insurance carrier, or within a week if receiving cheques from your insurance provider.

Option 2 Assignment (Direct Billing)

- ☐ Symmetry Dental will accept direct payment from your insurance company. You are responsible for any amount that your insurance provider does not pay. For our office to do this, we require the following:
  - Any portion not covered by insurance must be paid at the time of service
  - Patients are responsible for any outstanding balances after insurance paid
  - VALID CREDIT CARD ON FILE

I authorize Symmetry Dental to place through any outstanding balance automatically on my credit card:

VISA: _____- _____-_____-_____ EXPIRY DATE: ____-____

MC: _____- _____-_____-_____ EXPIRY DATE: ____-____

LATE OR MISSED APPOINTMENT FEE

We do our best to respect our patient`s time and in turn, ask for the same courtesy. Therefore, our office requires **48 hours – 2 business days** to change or reschedule a scheduled appointment. If we are not provided with such notice, a fee of $50.00 will be charged. This fee must be paid before any further appointments.

SIGNATURE:_____ **DATE:**_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____
Person`s Name

Please Check One: Internet____Facebook____Walk Ins_____Radio____ Other_____