Patient Information

JAMES P. WELLER DDS

Thank you for choosing our practice for your dental needs. We appreciate you taking the time to complete this confidential questionnaire. If you have any questions or need assistance, please ask us - we will be happy to help.

When completing this form - Please Print!

Whom may we thank for referring you to us? _____

ABOUT YOU

Name _____ _____ _____
First *M. I.* *Last*

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

I prefer phone calls at ☐ Home ☐ Cell ☐ Work ☐ No Preference

Birth Date _____ Social Security # _____

☐ Male ☐ Female
☐ Minor
☐ Single ☐ Married
☐ Widowed
☐ Divorced
☐ Partnered

Primary E-mail Address _____ Alternate E-mail _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Name of person responsible for this account _____

Relationship to Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name _____ Phone _____ Group/Policy # _____

Insured's Name _____ Insured's Birth Date _____ Relation _____

Insurance ID # _____ Insured's Employer _____

Secondary Insurance

Insurance Co. Name _____ Phone _____ Group/Policy # _____

Insured's Name _____ Insured's Birth Date _____ Relation _____

Insurance ID # _____ Insured's Employer _____

Please continue to the next page.

CONFIDENTIAL

APPOINTMENTS POLICY

All office visits are scheduled by appointment only.

We appreciate that your time is valuable. To make your visit as efficient as possible, we ask that you arrive a few minutes in advance of your appointment. We make every effort to keep precisely to our daily schedule but we will adjust the schedule when a patient arrives in pain or when a treatment takes more time than expected. We appreciate your understanding and cooperation.

If circumstances require dramatic changes to the schedule, we will do our best to notify you as far in advance as possible. If you are unable to make your appointment, please let us know right away and we will be happy to reschedule.

FINANCIAL POLICY

Dr. Weller's office accepts a wide variety of dental insurance plans. Our knowledgeable office staff will work with your insurance company and help you estimate your benefits.

We must emphasize that as dental care providers our relationship is with you, *not your insurance company*. While the filing of insurance claims and checking on your benefits is a service that we extend to our patients, all charges are your responsibility from the date services are rendered.

We accept all major credit cards, cash and checks. All treatment planned patients will be given a financial arrangement agreement that coordinates with your dental care.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. James P. Weller, DDS. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to such treatment. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize Dr. James P. Weller, DDS to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals as required.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. James P. Weller, DDS.

Office Policies
I acknowledge and agree to the Appointments Policy and the Financial Policy. I hereby acknowledge that I have received a copy of this practice's Privacy Policy and understand that I may ask any questions I have regarding the Privacy Policy.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

CONFIDENTIAL