Thank you for choosing Monroe Family Dentistry. To help us meet your entire dental healthcare needs, please fill out these forms completely. If you need any assistance or have any questions, please ask and we are happy to help.

Referrals are important to us! Please tell us how you heard about us:
Google_____Direct Mailer__________ Insurance__________Facebook ____________Twitter_________ Other________
If referred by someone, to whom may we thank for referring you? ________________________________________

How do you prefer us to contact you? Cell Phone / Home Phone / Email / Other________________________________

Name:___________________________________________Preferred Name: _________________________Sex : M F

Address:_________________________________________________________________Home Phone:_________________

City:______________________________________State:___________Zip:___________Cell Phone: __________________

SSN:_______________________________ Date of Birth: _____________________Work Phone:_____________________

Email:_______________________________________________________________________________________________

Circle appropriate answer: Minor Single / Married Divorced Widowed Separated

Patient or Parent/ Guardian Employer:________________________________________Work Phone:________________

Employer Address: ________________________________ City: _________________ State: _________ zip: ___________

Emergency Contact: ________________________________ Phone:__________________________________

**Responsible Party Information**

Name of person responsible for account:_________________________________________________________________
Address: ________________________________ City: _________________________State: ___________ Zip: __________

Phone: ___________________________Email:________________________Relationship to Patient: __________________

**Insurance Information**

Name of insured: ____________________________________________________Relationship to patient: ______________

Address: _________________________________City: ________________________State: __________Zip: ____________

Phone: ___________________________Email:______________________________DOB: ____________________________

Insurance Company: ________________________________________Name of Employer: ___________________________

Policy/ID Number: _________________________Group Number: ____________Ins Phone Number: _________________

Patient/ Responsible Party Signature: ______________________________________________Date:___________________

Please read the following policies carefully to minimize billing and insurance problems:

## Insurance Policy

Your insurance company does not guarantee any payment of services until the claim we submit has been received and reviewed. Therefore, your portion of services performed in this office is only an ESTIMATE and due payable at the time of service.

Dental insurance has deductible and year maximums. Please familiarize yourself with your plan's specifics and notify us as soon as possible when any charges are made.

Charges that are denied by your insurance company are your responsibility. If you have questions regarding this action, you should contact your employer or the insurance company directly for an explanation. Covered procedures differ from plan to plan and it is impossible for us to know the details of each plan.

## Dismissal Policy:

When patients miss appointments, cancel at the last minute, or show up late for their appointments, it greatly effects our schedule, as well as other patients appointments. Therefore, we require a 24 hour notice to cancel and/or reschedule an appointment. In the event that you have more than three broken appointments, late cancellations, or frequently show up late for your appointment, you be dismissed from our practice. Leaving a voicemail to cancel within 24 hours is considered a late cancellation.

## Other Office Policies

We also ask that you abide by the following rules while in our office so that we can service your dental needs in the best way possible:

- Cell Phones are not to be used in our office. Please step outside if you need to make a call.
- If you are more than 15 minutes late for your appointment, you may have to reschedule.
- When you are late, it counts towards our dismissal policy.

I understand my responsibilities as outlined about and will abide by them.

Patient's Name: ____________________________________________________________Date: ___________

Patient or Guardian's Signature: ________________________________________________________________

## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ___________________________________________________________________________

Address: ___________________________________________________________________________________

Signature: ______________________________________________Date:___________________________