

Not Your Daddy's Dentist

Dr. Sahf & Team

Patient information

Date of birth _____ Male Female

Patient name _____
First Initial Last

How do you wish to be addressed _____

Residence address _____

City _____ State _____ Zip _____

Home phone # _____ Cell# _____

E-mail address _____

Patient Social Security # _____

If child,

Parents name _____
First Initial Last

How did you hear about our office _____

Do you need antibiotics before dental treatment _____

Please circle one: Married Single Widowed Divorced

Someone to notify in case of emergency _____

_____ & phone # _____

Employment

Patient/parent employed by _____

Business address _____

City _____ State _____ Zip _____

Business phone # _____ Ext. _____

Present position _____

Dental insurance

Employee name _____
First Initial Last

Employee date of birth _____

Employer _____

Patient name _____

Employees Social Security # _____

Name of insurance co. _____

Insurance co. address _____

City _____ State _____ Zip _____

Insurance co. phone # _____

Insurance co. fax # _____

Group ID # _____

Please understand that we have no contract with your insurance company but we are happy to file your insurance claims at no charge to you, and help you receive the maximum benefits to which you are entitled; however, we cannot guarantee any **estimated** coverage. **Our contract for services and payment is with you, not the insurance company.** The **estimate** of insurance coverage is not a guarantee of insurance payment, **it is merely an estimate.** In summary, your insurance company may not pay their full **estimated** portion and you agree to be responsible for the total fee regardless of what your insurance pays. After payment has been received from your insurance company, and if they have not paid their **estimated** portion, we will send you a statement asking for the remaining balance. If your insurance company has not paid their **estimated** portion within 60 days from the start of treatment, you are responsible for the remaining balance at that time. **Our office does not file or accept assignment of benefits (payment) from a secondary insurance company.**

Release:

I authorize the dentist to perform diagnostic procedures and treatment (that has been agreed upon by patient and dentist) as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to other health care providers and to Dr. Scott Sahf.

I hereby give Dr. Sahf the absolute right and permission to use my audio/visual materials, including photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials.

I agree that the information on this page is, to the best of my knowledge, accurate and complete and may be used to obtain credit information, if needed.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to Dr. Sahf otherwise payable to me.

LIMITED RELATIONSHIP OF THE EMERGENCY PATIENT

I realize that my relationship with Dr. Sahf is limited to my dental visit today.

I understand that if Dr. Sahf recommends that I am in need of further treatment, it is my responsibility to make and keep that appointment and be sure that I receive further care.

Patient or guardian signature _____ Date _____

To be filled out by office personnel

Insured/Patient Name _____ DOB: _____ SS# _____

Effective date _____ Deductible _____ & does it apply to preventative Yes or No?

Waiting period _____ Calendar year maximum _____

Cleanings 2x/yr ____ or every 6mo _____ 00210 can do every ____ Yrs

Coverage by %: Preventative ____% , Basic ____% , Major ____%

Do you cover composites-Anterior _____ (02330-02335) % _____

-Posterior _____ (02391-02394) % _____

Build up (2950) % _____

Crowns, Inlays & Onlays (2510-2792) % _____

Bridges % _____

Dentures % _____

Sealants (01351) for children covered? _____ What age end _____

Fluoride for child covered? _____ What age end _____

Do you cover Endo (03110-03330)? _____ @ % _____

Is (04355) covered? _____ at what % _____

Is periodontal therapy covered (04341)? _____ at what % _____

Is periodontal therapy covered (04910)? _____ at what % _____

Extractions covered (07140-07250) @ what % ? _____

Veneers covered (02960-02962)? _Mostly reviewed_

Are there any other limitations? _____

Replacement period: Crowns & Bridges _____ Yrs, Dentures _____ Yrs, Fillings _____ Yrs

Is there a missing tooth clause for bridges? _____

Insurance contact person _____ Date of conversation _____

Insurance email address (website) _____

Insurance Fax # _____

Payor ID# _____