BRENTWOOD DENTAL SPECIALISTS, LLC
Alexandra Hendricks, D.M.D.

Patient Name ______ Sex: M F Birthdate: ______ Age: ______ Today's Date: ______

Home Address ______ City ______ State ______ Zip ______

Parent W/Child Today ______ Occupation: ______ Home Number: ______

Address (if different than above) ______ Cell Number: ______

Employer ______ Email Address: ______ Work Number: ______

Name of Spouse ______ Email Address: ______ Work Number: ______

Spouse Employer ______ Spouse Soc Sec # ______ Cell Number: ______

Reason for Today's Visit: ______ Who referred you to us? ______

DENTAL INSURANCE INFORMATION (Primary Carrier)	DENTAL INSURANCE INFORMATION (Secondary Carrier)
Insured's Name:	Insured's Name:
DOB:	DOB:
SSN#:	SSN#:
Insured's Employer:	Insured's Employer
Insurance Company:	Insurance Company:
Insurance Co. Address:	Insurance Co. Address:
Phone #:	Phone#:
Group #:	Group #:
Member ID #:	Member ID #:

OFFICE & FINANCIAL POLICY

Thank you for choosing Brentwood Dental Specialists as your child's dental healthcare provider. We are committed to providing your child with the highest quality dental care for their optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time of service. Our office accepts cash, personal checks, American Express, MasterCard, Visa, Discover and debit cards. Outside financing is available upon request and approval. PLEASE NOTE: Returned checks are subject to additional fees. In the case that it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

As a courtesy to our valued patients that have insurance plans, our office will check eligibility, benefits and file insurance claims for reimbursement for all rendered dental services. *However, eligibility and financial reimbursement from your insurance company is NOT a guarantee of coverage and reimbursement, as actual benefit payments are determined only when the claim is processed by your insurance company. Therefore, if the estimated portion of a third party payment does not fully reimburse for the dental treatment rendered, the financially responsible person is responsible for the remainder of the balance.* Co-payments, deductibles and estimated payment portions for our accepted insurance plans are **DUE** in full at the time of dental treatment. On orthodontic appliances (space maintainers, expanders, retainers, etc.) our office requires a 50% deposit before they are fabricated and the remaining 50% is due when appliances are delivered, if the appliances are not covered by insurance. A $50 office fee will be assessed to the financially responsible person and/or guardian in the event that accepted and scheduled dental treatment is unable to be completed due to non-compliance and/or uncooperative behavior by the patient as well as if sedative medication is spilled by the parent or the child (accidently or purposely) and more medication must be prepared. Broken appointments (no call/no show and without at least 24 hours notice) will be charged $50 (for each sibling) after the second occurrence, to the financially responsible person and/or legal guardian, if not prohibited by the insurance company. This office reserves the right to request a refundable deposit for scheduling more than one child for consecutive appointments on the same day. There will be a $25 fee charged for any returned checks (insufficient funds). If necessary, a collection agency will be employed to collect overdue accounts and the collection fee will be charged to the patient's account. Consequently, credit agencies will be notified of delinquent accounts. This office reserves the right to discontinue treatment/cancel all future appointments of any patient (or family) who has cancelled, failed or we are not able to confirm scheduled appointments for **THREE** scheduled appointments. Your insurance company may be notified of your discontinued treatment.

I, as the financially responsible person and/or guardian for this account, certify that I have read, understood and agreed to this office policy.

______
Signature Date Patients Name