WENDY L. WELLS, D.M.D PC

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Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________* ____________* ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* ________ **Prev. Visit:** ________ **Email Address:**
____

Phone: ________* ________ ________ ____ **Best time to call:** ____________
Home Mobile Work Ext

Address: ____________________* ____________________
Address 1 Address 2

____________________* ______* _____-____*
City State Zip Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

____

Spouse or Responsible Party Information

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________* ____________* ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* ________ **Email Address:** ____________________

Phone: ________* ________ ________ ____ **Best time to call:** ____________
Home Mobile Work Ext

Address: ____________________* ____________________
Address 1 Address 2

____________________* ______* _____-____*
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____________________ **Phone:** __________

Employer Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ____________________ ____________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** __________ **Group #:** __________

Insured's Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Insured's Employer Name: ____________________

Employer Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________________

Insurance Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ____________________ ____________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** __________ **Group #:** __________

Insured's Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Insured's Employer Name: ____________________

Employer Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ ______-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________ ______________________

Address 1 Address 2

______________________ ________ _____-____

City State Zip Code

Truth-In-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Even if you have medical and/or dental insurance assistance, remember that your coverage is a contract between you and your insurance company. Patients who carry dental insurance understand that all dental services are charged directly to the patient and that you are personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

Addressing the insurance prior to treatment will inform you of your estimated non-insurance co-pay, remember, this is never a guarantee of payment. If your insurance company requests additional information (e.g. chart copies of records, detailed reports) we will be happy to provide such information. However, a fee may be charged for this service depending on the request, and will be billed directly to you.

YOU ARE RESPONSIBLE FOR PAYING YOUR BILL

A service charge of 1 % per month on the unpaid balance will be charged on all accounts with a balance exceeding 90 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. If any insurance pays after I have paid, I understand the credit will be issued to me.

I grant my permission to you or your assignee, to telephone, text or email me at home, work or any other number I have listed to discuss my account.

For minor patients, the parent/guardian accompanying the minor is responsible for full payment.

There can be changes with treatment; this does not guarantee this is exactly what will be done. Your best interest is our goal.

Please note: There may a be a duplicating fee of up to $100 billed directly to you for any request to send records to another office not referred to by Wells Family Dentistry.

Missed appointment policy
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50 per routine appointment and $100 for extended appointments. Please help us to serve you better by keeping scheduled appointments.

☐ ***I agree to honor the policies outlined above. I agree to make full payment for services rendered on the day of appointment unless prior arrangements have been made in writing. The undersigned, responsible party, agrees to be personally responsible for all charges, if at any time, or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Wells Family Dentistry to bill their account finances charges as described above. In the event it becomes necessary for Wells Family Dentistry to incur collection cost, a 33% collection fee will be added to the account. In the event it becomes necessary for Wells Family Dentistry to institute suit to collect any amount due under this agreement, the undersigned also agrees to pay court costs plus all legal fees including reasonable attorneys' fees if incurred for collection and submits to jurisdiction and venue in Whiteside County, IL. I hereby certify that I have read and agree to the above terms.**

Relationship to Patient:

____

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Response Date: ________