Schaefer
Aesthetic General Dentistry

David A. Schaefer, DMD

PATIENT INFORMATION:

Name_________________________________ DOB___/___/_____ Social Security #____________________

Address____ Home Phone________________________

City____________________________ State____ Zip__________Cell Phone_________________________

Occupation____________________ Work Phone________________ Email __________________________

Employed by_________________________________ Work Address________________________________

Spouse______________________ Referred by____

Name of nearest relative, not living with you________________________Phone_______________________

PERSON RESPONSIBLE FOR ACCOUNT: (if same as patient, proceed to next section)

Name_____________________________________ Social Security No.________________________________

Address_________________________ City______________________ State_____ Zip_________

Relationship to patient_____________________ Home Phone_____________Work Phone_______________

Employed by_____________________________Business address__________________________________

INSURANCE INFORMATION: Please present insurance card at front desk

Insurance Co.___________________________________

Policy Holder____________________________________ Policy Number______________________

INSURANCE ASSISTANCE: We will be happy to assist you in filing for your insurance benefits. It is important to remember that your insurance is a contract between you, your employer and the insurance company. We cannot be responsible for what your insurance carrier will or will not pay. We request that you take the responsibility for knowing what your benefit package includes. Please understand that there are hundreds of different benefit packages offered by numerous insurance companies, and we cannot possibly know the details of each one. We can provide you with an ESTIMATED benefit on which to base your copay, however, this is just an estimate. We view insurance as a helper to the patient, but do not expect it to cover all procedures or the total treatment needed. If your insurance does not pay or deny within 30 days, which is required by law, you will then be responsible for the remaining balance on your account. We request that co-payments are paid at the time of service. Convenient payment plans are available if necessary.

PREFFERED METHOD OF PAYMENT:

____Cash ____Check ____Credit Card VISA/MASTER CARD/DISCOVER/AMERICAN EXPRESS
Card No.________________________ Exp___________

Please note: A service charge of 1.5% per month (18% annually) will be applied to all past due accounts. There will be a $20 service charge applied to all returned checks.
should my account go into collection procedures, I understand that Dr. Schaefer reserves the right to collect any fees incurred in the collection of my account, including but not limited to attorneys fees, collection agency fees and billing fees.

Signature_______________________________________ Date___________________________