Patient Information **Date____/_____/_____**

Patient's Name_____

Cell Number _____ Home Phone_____

Email Address:_____

Male ☐ Female ☐ Married ☐ Single ☐ Widow ☐ Child ☐

Address _____State_____ Zip Code_____

Patient's Birth date _____ Patient's Social Security Number_____

Responsible Party_____Birthdate_____

Employer_____ Work Phone# _____

Occupation_____ How long Employed_____

Dental Insurance: ☐ Yes ☐ No Social Security #_____

Address (if different from patient)_____
Phone #_____

Spouse/or Secondary Ins. Party_____Birthdate_____

Employer_____ Work Phone# _____

Occupation_____ How long Employed_____

Dental Insurance: ☐ Yes ☐ No Social Security #_____

Address (if different from Patient)_____
Phone #_____

Name of nearest relative or friend not living with you_____

Phone#_____

Referral Information

Whom may we thank for referring you to our practice? _____

How did you learn about our practice? (Please Circle)

Friend/ Family Dental Office Website Work School Other (Specify)_____

****Payment is due in full at the time of service for patients without dental insurance. Patients with insurance are required to pay deductibles at the time of service and are responsible for all dental services, although as a courtesy we will submit insurance claims. Office policy requires 24 hour notice for cancelled appointments. If we do not receive 24 hour notice, there will be a minimum fee of $25.00.
I have read the above conditions of treatment and agree to their content.

X_____Date _____
Signature of Patient, Parent, or Guardian

Payment Information

Written Financial Policy

Thank you for choosing Donald A. DeChellis, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care easy and manageable for our patients by offering several payment options.

Payment Options:

- Cash, Check, Credit Card (Visa, MasterCard, Discover)

We offer a **10%** Courtesy Discount to patients who pay in full prior to the completion of care with **Cash or Check**.

We offer a **5%** Courtesy Discount to patients who pay in full at time of visit with **Credit card, debit/check card, or HSA card.**

- Convenient Monthly Payment Plans[1] from CareCredit
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

Please Note:
Payment is due in full at the time of service for patients without dental insurance.
For plans requiring multiple appointments, alternative payment arrangements may be provided.

Donald A. DeChellis, DDS requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance, your insurance contract is between you, your employer, and the insurance company. We are happy to submit a claim to your carrier as a courtesy to you for reimbursement for your treatment.[2] However, deductibles and co-pays are due at the time of service.

Donald A. DeChellis, DDS charges $30 for returned checks.

We will apply a service charge of 1.5% PER MONTH (18% annually) on unpaid balances exceeding 30 days.

Office policy requires 24 hour notice for cancelled appointments. If we do not receive 24 hour notice, there will be a minimum fee of $25.00.

I have read the above financial policies and conditions of treatment and agree to their content.

X_____Date _____
Signature of Patient, Parent, or Guardian

[1] Subject to Credit Approval

[2] However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.