



SWISS BIOLOGIC DENTISTRY

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Phoenix, Arizona 85014
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PATIENT AND INSURANCE INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Phone: [Home [Work [Cell Email: _____

Yes **No** I give permission to Swiss Biologic Dentistry to leave my personal dental information (i.e. treatment plans, ledger/statements, questions or concerns regarding treatment etc.) on the answering machine and/or email address listed above, Initial _____.

Yes **No** I give permission to Swiss Biologic Dentistry to share my personal dental information (i.e. treatment plans, ledger/statements, x-rays, medical history, etc.) with anyone on my family file, or the following named persons _____, Initial _____.

Date of Birth: _____ Social Security Number: _____

Employer: _____

If full time student, name of school: _____

Name of person responsible for account: _____

Address/ Phone (if different from above): _____

Name of Spouse/Partner: _____

Spouse/Partner's Employer: _____

Emergency Contact: _____

Relationship: _____ Phone: _____ Address: _____

How did you hear about us? _____

By what name do you prefer to be called? _____

Your Preferred Pharmacy _____ Phone _____

Pharmacy Address _____ or Pharmacy Cross Streets _____

INSURANCE INFORMATION

First Insurance Company: _____ Effective Date: _____

Address: _____

Policy/ Subscriber Name: _____ Employer: _____

Member ID: _____ Birthdate: _____ Group Policy#: _____

Relation to Patient: Self Spouse Child Other

Second Insurance Company: _____ Effective Date: _____

Address: _____

Policy/ Subscriber Name: _____ Employer: _____

Social Security#/ Member ID: _____ Birthdate: _____ Group Policy#: _____

Relation to Patient: Self Spouse Child Other

FINANCIAL AGREEMENT

I understand that all responsibility for payment for dental provided in the office for my dependents or myself is mine, due and payable at times services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon date. I understand that a 1.5% finance charge (18% APR) may be added to my account.

INSURANCE FILING

You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however, file dental benefit claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. Some insurance companies arbitrarily select certain procedures they will not cover. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

COLLECTION PROCEEDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees. In addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS

I understand that when I book my appointment, Swiss Biologic Dentistry is holding a space on their calendar for me that is no longer available to other patients. In the event that I need to reschedule, I will give Swiss Biologic Dentistry notice **2 business days prior to my scheduled appointment. If an appointment is missed without notice, this office reserves the right to charge for missed appointments at \$100 per scheduled hour missed.**

For hygiene patients only, we require 24 hour notice of cancellation or there will be a \$50 cancellation fee assessed. Hygiene appointments are in very high demand, and every slot is important. There are always patients who need to come in for a cleaning and failing to provide adequate notice prevents this office from getting a different patient scheduled into that available slot.

RETURNED CHECKS

I understand that there will be a \$35.00 insufficient funds fee added to my account in the event of a returned check.

ARBITRATION

I understand that any dispute as to medical services, or any other issue arising out of services rendered by swiss Biologic Dentistry, LLC, its owners, its staff, or third-party contractors, will be determined by submission to binding arbitration as provided by Arizona law, and not by lawsuit or court process unless Arizona law provides otherwise. Both parties to this agreement expressly waive their right to a trial by jury and instead accept the use of binding arbitration. Each party shall submit the names of three potential arbiters and the two sides shall then come to an agreement and choose a presiding arbiter among the potential arbiters

CHANGE OF INFORMATION

I understand that it is my responsibility to advise this office of any change in the information I provide regarding my insurance, patient information, or the health history form.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

PATIENT DISMISSAL

I understand that there are grounds for immediate dismissal as a patient from Swiss Biologic Dentistry if any offenses are committed; these offenses include, but are not limited to: rude or abusive behavior toward any staff member, non-compliance with treatment plan, medication misuse, multiple missed office visits, failure to pay on account. Failure to be dismissed due to one offense is not a waiver of being dismissed for other offenses.

Signature of Patient/Parent or Guardian

Date