Medication History

Drug Name	Dosage	Frequency	Date Started	Date ended /Current

____

Signature **Date**

Welcome to Trailside Dental Care

This letter is to acquaint our patients with our general office policies to help avoid any misunderstandings.

Our responsibilities are to you as our patient. We practice preventative dentistry and stress the importance of regular care to help you in your goal to achieve and maintain excellent dental health.

Insurance Patients: If you have dental insurance, it is your responsibility to bring a completed and signed form with you. We will file insurance claims as a courtesy to our patients. Remember that your insurance contract is between you and your insurance carrier. It is your responsibility to be aware of your insurance available for each treatment, any specific clause stated in your policy, and/or deductibles and waiting periods. Insured patients should be prepared to pay their co-pay and/or deductibles at the time of service. If your insurance company pays only part of your bill or rejects your claim you are financially responsible for the balance. The balance will be due upon the receipt of your next statement. It is also your responsibility to be sure that we are a listed provider with your insurance carrier.

Patients with No Insurance: Patients with no insurance are expected to pay in full at the time services are rendered, unless prior arrangements are made.

Payment Methods: We accept Visa, Master Card, Discover, American Express, Care Credit, Cash, Personal Checks, **Checks written with insufficient amounts will have accounts billed $50 for each bad check.** Statements will be sent monthly.

Delinquent Accounts: Any fees, such as Attorney's Fees and Court Cost incurred as a result of overdue accounts will be the patients complete financial responsibility.

We try to see our patients as promptly as possible. However, there are times when emergencies and/ or surgeries may result causing unavoidable delays.

****We ask that our patients please give us at least 24-hours' notice when canceling an appointment. Failure to do so will result in a "broken appointment charge." A $50 fee**

Our goal is to make your appointment as comfortable, safe, and pleasant as possible. If you should have any questions or suggestions, please feel free to discuss them with our doctor and staff.

"I have read or have had read to me and understand my responsibility listed in the above policies."

_____

Patient's Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I, _____, have received a copy of the office's Notice of Privacy Practices.

☐ Check if you give us permission to leave a message at home or with someone regarding your appointment.

Please print name Date

Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

1- Individual refused to sign
2- Communication barriers prohibited obtaining acknowledgment
3- An emergency situation prevented us from obtaining acknowledgement
4- Other (please specify)
5-