

T. LANCE COLLIER, DMD, LLC

Family Practice *of* General Dentistry

NEW PATIENT REGISTRATION

Please provide us the following information.

GENERAL INFORMATION

Name _____ Preferred: _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ FAX (_____) _____

Date of Birth ____/____/____ SSN _____

Marital Status: Single Married Divorced Separated Widowed

EMPLOYMENT INFORMATION

Employer _____ Occupation/Job Title _____

Employer's Address _____

SPOUSE INFORMATION – OR – PARENT/GUARDIAN (if patient is a child/minor)

Spouse's Name _____

Employer _____ Work Phone (_____) _____

SSN _____ Date of Birth ____/____/____

RESPONSIBLE PARTY. WHO IS RESPONSIBLE FOR YOUR CHARGES TODAY?

Responsible Party's Name _____

Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Relationship to Patient _____ Phone No.(_____) _____

PHYSICIAN CONTACT INFORMATION

Name of Primary Physician or Clinic _____

Address _____ Phone No. (_____) _____

Date of Last Medical Exam _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

INTERNET MAGAZINE AD FRIEND PHONEBOOK INSURANCE CARRIER

OTHER: _____

INSURANCE INFORMATION

Insurance Co. _____

Name of Insured _____

Individual No. _____ Group No. _____

Insured's Date of Birth _____/_____/_____ Insured's SSN _____

Relationship to Insured _____ Insured's Employer _____

APPOINTMENT REMINDERS & ONLINE ACCOUNT ACCESS

APPOINTMENT REMINDER, CONFIRMATION, LATE ARRIVAL AND CANCELLATION POLICIES

As a complimentary service, our office utilizes an automated system for appointment reminders and confirmations. The system is structured using emails, text messages, and automated phone calls. This works well if you are "on-the-go" and prefer to have Appointment Reminders electronically delivered to your Inbox or Mobile Phone. Appointments can be confirmed by clicking a link in reminder emails, by responding with the letter "C" to text reminders, or by following instructions given during automated phone calls. Our office will also contact you by phone directly to remind you of your appointment.

Your appointments are specifically reserved for you. **Please plan to arrive 10-15 minutes early for your scheduled appointments.** As delays in the daily treatment schedule can adversely impact treatment for other patients, excessively late arrival for an appointment may require rescheduling at the practice's discretion. Though, we do understand that unforeseen issues can arise on occasion and you may need to cancel or reschedule your appointment, please be mindful that missed appointments prevent other patients with dental needs from being seen. Thus, we respectfully request **at minimum 24 hours advance notice** if you are unable to arrive for your scheduled appointment time. **In instances of habitual tardiness, short-term cancellation, or failure to show for scheduled appointments, the practice may charge (at its discretion) a penalty fee to your account.**

I authorize T. LANCE COLLIER, DMD, LLC to send my appointment reminders electronically via Email to the email address above and Text Message* to the mobile number above.

MY MOBILE CARRIER: T-Mobile Sprint Verizon AT&T Other: _____

**This service is offered free of charge, however, standard text messaging rates from your mobile carrier may apply.*

SECURE ONLINE ACCOUNT ACCESS VIA OUR WEBSITE

Our office provides convenient and secure online access to your patient account via the "My Account" link on our website, **www.DrLanceCollier.com**. This service is free of charge and allows you to view upcoming scheduled appointments for you and your family, treatment history, treatment plans and current balance at any time. You can also access your statements and make payments on your account. Once enrolled, you will receive a password from our office via email, and can begin accessing your account immediately.

FINANCIAL POLICY STATEMENT:

Payment is due at the time services are rendered. Our office is an in-network provider for a select group of insurance carriers. As a courtesy to you, we may communicate with your insurance carrier to gather information on your eligibility and limits of benefits, and we may file claims on your behalf for treatment provided in this office. In this regard, we accept most traditional insurance policies. Patients with dental insurance are expected to pay their estimated deductibles and co-insurance at the time of treatment. Following claim payment, any remaining balance is your responsibility. Please be advised, though our office will make every effort to communicate to you accurate information with regards to your dental benefits, we are not and cannot be responsible for any inaccuracy of information conveyed from an insurance carrier. You are the policy holder, therefore an insurance carrier's obligation is to you and not to our office. Irrespective of any dental insurance benefits that might exist, you are always responsible for the entire cost of dental treatment. Those patients whose insurance carrier engages exclusively in direct reimbursement are required to pay for services in full at time of treatment; at our discretion, our office may file a claim on your behalf. We will be happy to discuss any special needs in the handling of your account. We accept cash, checks and credit cards.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

X Signature of Patient or Guardian _____ Date _____

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INITIAL CONSULTATION FORM

To help us get to know you, and to assist in learning your dental concerns, please provide us the following information.

NAME: _____ DATE: _____

In your own words, what is your main concern regarding your visit today? _____

How long have you lived in this area? _____ Approximate Date of your Last Dental Visit: _____

Are you in dental discomfort/pain today?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Previous Dentist: _____
Are your teeth sensitive to cold or sweets?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Previous Dentist's Phone #: _____
Are your teeth sensitive to hot or pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How do you feel about the appearance of your teeth? _____
Do you clench or grind your teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Do you have frequent "tension" headaches?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Are you missing any teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Are any of your teeth loose?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is there anything you would like to express about your dental health or past dental treatment? _____
Do your gums bleed when you floss or brush?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Have you ever been treated for gum disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Are you concerned with having bad breath?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Have you had orthodontic treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

Are there any specific dental treatments that you are interested in learning more about?

WHAT IS THE MOST IMPORTANT THING TO YOU IN CHOOSING A DENTIST OFFICE FOR YOU AND YOUR FAMILY'S NEEDS?

NOTES: