Richard D. Mercer, DMD

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Patient Questionnaire

Chart#:

FOR OFFICE USE ONLY

Patient Name: Last First MI

Preferred Name

Title: **Gender:** Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone: Home Mobile Work Ext

Fax Other

Address: Address 1

Address 2

City State Zip Code

Physician's Name: Phone:

Who may we thank for referring you to our practice?

Primary Dental Insurance

Name of Insured:

Last

First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Subscribers employer
Group #
subscriber ID #
Insurance phone #

Secondary Dental Insurance

Name of Insured:

Last

First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Subscribers employer
Group #
subscriber ID #
Insurance phone #

Responsible Party

Responsible Party: Relationship to patient: Phone Number:

Dental History

Date of last dental treatment: My current dental problem is:

Do you presently have or have you had, please check all that apply:

- ☐ Pain or discomfort in the mouth, face, or jaws.
- ☐ Aching or sensitive teeth.
- ☐ Had serious trouble associated with previous dental treatment
- ☐ Bleeding or sensitive gums.
- ☐ Had injury to face or jaw.
- ☐ Feel anxious about having dental treatment.

Acknowledgement of Privacy Practices

I acknowledge that I may obtain a copy of the Statement of Privacy for the office of Richard D. Mercer, DMD at my request. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights, responsibilities, and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also available in the facility.

If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

Any member of my immediate family: ◯ Yes ◯ No

Spouse: ◯ Yes ◯ No

Other: ◯ Yes ◯ No

If other, please specify:

Office Financial Protocol

We want you to feel comfortable with our office regarding your financial and insurance matters and thereby prevent misunderstandings. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. We hope you will contact us if you have any questions regarding our services or our financial policies. Many people are under the impression that if they have insurance, it is the insurance company who owes the doctor for his services. Please keep in mind that the insurance contract is between the patient and the insurance company. Therefore, the patient is responsible for the bill, regardless of the insurance coverage determination. As a courtesy to our patients, we are happy to bill your primary insurance for you, however the responsibility for payment remains with the patient (or guardian). If you have additional coverage we will assist you in billing your secondary policy.

Patients with insurance: At the time of service, patients are requested to make initial payment toward the estimated charges. If your insurance pays in addition to the balance due on your account, a refund will be sent to you promptly. Many insurance plans state that you will be covered up to 50%, 80% or 100%. In spite of that statement, we have found in actuality many plans may cover upon their established usual and customary fees, not our actual charges.

Patients without insurance: Patients without insurance are required to pay the charges in full at the time of service. A 5% cash courtesy will be applied for payment in full with cash or check. A 5% senior courtesy will be applied for payment in full with cash or check.

Major services: Down payment of 50% is required for any major services. Bleach tray and mouth guards must be paid in full at the time of service.

Payment options: Personal checks, cash, money orders or Visa, MasterCard or America Express may be used for payment on your account. There will be a charge for all returned checks, amount of charge will depend on current financial institutions fees for returned checks.

Account balances: The balance on all accounts is due in full within 60 days regardless of insurance coverage or anticipated payment from other sources. In the event that payment for our services is not made within 60 days of receipts of services, the interest charge of 1.5% per month (18% per year) will be added to the account.

Parental responsibility: Agreements between parents accepting or denying financial responsibility for dental charges are not recognized by this office. We consider the guardian (custodial) parent to be responsible for payment of services. Young adults (age 18 or older) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs a financial agreement. This is the case regardless of insurance benefits for which they may still be eligible.

Cancellation policy: Appointments canceled within 24 hours may be subject to a cancellation charge of $40.00. Frequent failure to keep scheduled appointments confirms to us that the patient/office relationship is not working. After multiple such events, the patient will be notified of dismissing the patient from the practice.

Assignment and release: I understand my insurance is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred, and authorize any insurance benefits to be paid directly to Richard D. Mercer, DMD. I also authorize Dr. Mercers office to release any information required for payment and processing of this claim.

☐ **By checking this box, I acknowledge that I have read the previous statements and agree to their contents.**

To the best of my knowledge, all the preceding answers are true and correct.

Signature _____ _____

Date _____

Response Date: _____