river's edge dental clinic

952.232.6454
16023 Elmhurst Lane, Suite 104
Lakeville, MN 55044

651.463.7777
Opening January 1st!
Farmington, MN 55024

Please fill out all information below as completely as possible.

Patient

Date _____ Dr. Mr. Mrs. Ms. (circle one) Sex _____

Name (last) _____ (first) _____ (middle) _____

Street Address _____ (city) _____ (state) _____ (zip) _____

Home Phone _____ Birthdate _____ Social Security # _____

Work Phone _____ Relationship to Responsible Party _____

If patient is a minor, parent's or guardian's name _____

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

Responsible Party

Dr. Mr. Mrs. Ms. (circle one)

Name (last) _____ (first) _____ (middle) _____

Street Address _____ (city) _____ (state) _____ (zip) _____

How long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____

Spouse's Name (last) _____ (first) _____ (middle) _____

Spouse's Employer _____ Occupation _____ Birthdate _____

Dental Insurance

Policyholder's Name _____ S.S.# _____ Birthdate _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ (city) _____ (state) _____ (zip) _____

Employer Name _____ Relationship to Patient _____

Are you covered by another dental plan? ❑ Yes ❑ No If yes:

Policyholder's Name _____ S.S.# _____ Birthdate _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ (city) _____ (state) _____ (zip) _____

Employer Name _____ Relationship to Patient _____

Emergency Contact

Name the nearest relative/friend not living with you _____

Complete Address _____ (city) _____ (state) _____ (zip) _____

Phone _____ Relationship to Patient _____

I have received, reviewed and understand the financial policy on the reverse side. I also understand that where appropriate, credit bureau reports may be obtained. Although we will try to estimate insurance benefits as best we can when applicable, we can in no way guarantee coverage. If you have any questions, please contact your insurance company.

Signature (parent's signature if minor) _____ (Date) _____

PLEASE REVIEW REGISTRATION ON OTHER SIDE

Financial Arrangements & Dental Insurance

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance of our payment policy.

Payment for services rendered are due at the time of service unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. We will be happy to process your insurance claim form for your reimbursement. For patients without insurance we do provide 5% discount for same day cash payment, and 15% for Seniors 65 years of age and older.

Returned checks and balances older than 30 days are subject to additional collection fees and interest charges of 1-1/2% per month. Charges may also be made for broken appointments cancelled without 72 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy, we will assist you with information; however, if you have any additional questions about coverage, please contact your insurance or human resource department. Estimates are not a guarantee of benefits.

2. Typical criteria and terms expressed by insurance carriers include:
   "Reasonable and Customary Fees"
   "Yearly maximums"
   "Pre-authorization"
   Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased by your insurance plan. If you feel the dental benefits are inadequate, discuss the matter with your employer so that alternatives can be investigated.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. Portions not covered by insurance are also due the same day services are rendered. Although we will try to give you a rough estimate, we cannot be responsible for verifying coverage with your insurance company. Please verify with your insurance for your available benefits.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Financial arrangements may be available. Please contact our office manager.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

CREDIT NOTICE: Please not that in the event your account is turned over to a collection agency and CREDIT MANAGEMENT for non-payment, there will be an additional charge of 40% of your unpaid balance, plus postage added to your account.

Date _____20_____ Signed_____