Bittner Family
DENTAL GROUP

Welcome

About You

Name: _____Today's Date: _____
I like to be called: _____ Date of Birth: _____
Social Security #: _____ Driver's Lic. #: _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other Spouse's Name _____
Employer: _____ Occupation: _____
Whom may we thank for referring you? _____
Why did you select our office? _____
Special Interests or Hobbies: _____

Contact Information

Home Address: _____ City, State, Zip: _____
Home Phone: _____Work Phone: _____
Email: _____ Cell Phone: _____ Carrier: _____
When is the best time to call you? _____ Where? _____
In case of an emergency, who may we contact on your behalf?
Name: _____ Phone: _____
Social Media: (Check all that apply) ❑ Instagram ❑ Facebook ❑ Yelp

Responsible Party Information

(Please fill out if different from above)
Name: _____ Relation to Patient: _____
Social Security #: _____ Driver's Lic. #: _____
Home Phone: _____ Work Phone: _____
Home Address: _____ City, State, Zip _____

Financial Information

Person responsible for payment of services: _____
Please check the appropriate box(es):

- ❑ Cash and personal checks are accepted. As a special service to you, we offer a cash courtesy if you pay for your entire treatment in full, in advance.
- ❑ With dental insurance, we strive for you to receive your maximum benefits. While we will assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover.
- ❑ Mastercard, Visa, American Express & Discover

- ❑ For long term or extended payments, we offer a healthcare financing program which, when you are accepted, we will allow small monthly payments for the treatment received.

Insurance Information

Primary Dental Insurance:
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/Policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____
Additional Dental Insurance:
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/Policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____

Consent for Services & Financial Policy

I understand that financial arrangements must be made in advance, as a condition of my treatment in this office. I understand that dental services performed without previous financial arrangements must be paid in full at the time services are rendered. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that the fee estimate listed for my dental care can only be extended for a period of 90 days from the date of the patient examination.

As a courtesy to patients who carry dental insurance, we will gladly bill your insurance for you. However, this dental office cannot render services on the assumption that our charges will be paid in full by any insurance company. Nevertheless, you are responsible for portions not covered by your dental insurance and this may include deductible, co-pay, coinsurance, UCR or non-covered services according to your plan provisions. A service charge of 1½ % (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that appointment times are reserved especially for me. We require a courtesy notice of cancellation at least 2 business days before the time of appointment. There is a cancellation fee of $200 for appointments cancelled less than 2 business days prior to your reserved appointment.

I have reviewed a copy of the Dental Material Facts Sheet as required by law.

I grant my permission to the office of Dr. Bittner Jr. to telephone me at home or at my work to discuss matters related to this form.

I authorize Bittner Dental Group to take photos and/or videos. I understand that they will be used as a record of my care, and may be used for communication with other health care professionals and educational publications/lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc). I do not expect compensation, financial or otherwise, for the use of these media. If I wish to revoke this consent, I may do so in writing.

I have read the above conditions of treatment and payment and agree to their content.

Name of Patient (Print): _____
Signature: _____ Today's Date: _____