WELCOME TO OUR OFFICE ... **INCREDIBLE SMILES OF TEXAS**

PATIENT INFORMATION (Please Print)

PATIENT'S NAME	MARITIAL STATUS S | M | W | DIV |SEP	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE NO.	CELL PHONE/PAGER
EMPLOYER'S STREET ADDRESS, CITY, STATE, ZIP CODE		E-MAIL ADDRESS	
NEAREST RELATIVE NOT LIVING WITH YOU	STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO.
SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO.	
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE NO.	CELL PHONE/PAGER
EMPLOYER'S STREET ADDRESS, CITY, STATE, ZIP CODE		E-MAIL ADDRESS	
NAMES AND AGES OF YOUR CHILDREN		REFERRED BY	

DENTAL/MEDICAL INFORMATION

DATE OF LAST DENTAL VISIT	WHAT, IN YOUR OPINION, IS THE DENTAL PROBLEM?	
ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME?	YES	NO
HAVE YOU EVER HAD A BAD EXPERIENCE IN THE DENTAL OFFICE?	YES	NO
HOW WOULD YOU RATE:		
THE GENERAL CONDITION OF YOUR TEETH?	GOOD	FAIR POOR
THE APPEARANCE OF YOUR TEETH: COLOR, SPACING, PROFILE?	GOOD	FAIR POOR
THE CONDITION OF YOUR GUMS?	GOOD	FAIR POOR
YOUR PREVIOUS DENTAL TREATMENT?	GOOD	FAIR POOR
WHAT IS YOUR REACTION TO HAVING DENTAL WORK DONE?	DREAD IT	WORRY ABOUT IT DON'T MIND IT
IF YOU COULD CHANGE YOUR SMILE, WHAT WOULD YOU LIKE TO CHANGE?		
WHAT ARE YOU EXPECTING TO HAVE DONE TODAY?		

INSURANCE INFORMATION

IS PATIENT COVERED BY DENTAL INSURANCE?	IF SO, NAME OF COMPANY	
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.

Incredible Smiles of Texas
Financial Policy

Thank you for choosing Incredible Smiles of Texas for your dental needs. We are committed to providing you with excellent care. We will always discuss financial arrangements prior to dental treatment.

Payment in full the day of service is appreciated. Your estimated co-payment for all procedures must be paid the date of service. We gladly accept Visa, Mastercard, Discover, American Express, cash, check and Care Credit. Incredible Smiles of Texas is only an in-network provider for Delta Premier and United Concordia. All other insurance plans are considered out-of-network. Our office is committed to helping our patients maximize their dental benefits, however, all insurance carriers vary greatly. We make every effort to give the best estimate possible, however, we can only ESTIMATE in good faith, not guarantee payment or coverage from your insurance carrier. We are happy to assist you by filing your insurance claims, at no charge to you, on the date of service. It is, however, your responsibility to follow up with your insurance company to ensure prompt payment to our office. If your insurance does not pay for all anticipated fees, or does not pay in a timely manner, you will be responsible for the balance.

If you are unable to keep a scheduled appointment, kindly give us 24-hour notice. Please remember we have reserved this time specifically for you, so a 24-hour notice is greatly appreciated so we may offer the time to another patient. There will be a
$30.00 charge if you do not show up for your reserved appointment. After two missed appointments without notice, we will be unable to reserve time for you. You may call the office and we may be able to accommodate you the day you call.

A service charge of 18% annual percentage rate (1.5% monthly) will be assessed to all accounts past due 60 days. A fee of $35.00 will be charged for all returned checks. Any fees incurred to collect payment will be charged to the patient or guardian.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

I understand I am responsible for notifying Incredible Smiles of Texas of any changes in my insurance coverage or personal information.

The patient or guardian agrees to be fully responsible for total payment regardless of insurance status.

_____ _____

Name of Patient Name of Responsible Party

_____ _____

Signature of Responsible Party Date