



- o Grinding teeth
- o Clicking or popping jaw
- o Clenching
- o Headaches

- o Snoring or sleep apnea
- o Sensitivity to hot, cold, or sweet foods
- o Red, puffy, or tender gums
- o Teeth have moved

**Insurance Information**

**Primary Insurance Policy**

Name of Policy Holder: \_\_\_\_\_ Is the Policy Holder a patient? Yes No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID#: \_\_\_\_\_ Group #  
\_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient's relationship to policy Holder:  
\_\_\_\_\_

Dental Insurance Company Name: \_\_\_\_\_ Phone  
# \_\_\_\_\_

**Secondary Insurance Policy**

Name of Policy Holder: \_\_\_\_\_ Is the Policy Holder a patient? Yes No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID#: \_\_\_\_\_ Group #  
\_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient's relationship to policy Holder:  
\_\_\_\_\_

Dental Insurance Company Name: \_\_\_\_\_ Phone  
# \_\_\_\_\_

Please be aware that we collect the full amount of the balance at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefits. As a courtesy to you we will file your claims with your insurance company. Insurance payments will be sent to the address that you have on file with your insurance company and are normally received within 30 to 45 days. A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefits: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all cost of dental treatment.

Signature of patient, parent or guardian: \_\_\_\_\_ Date:  
\_\_\_\_\_

**Financial Considerations and Payment Policies**

Our office has been designed, set-up and staffed to offer you the finest dental care available. Our goal is to deliver quality dentistry in a comfortable relaxed environment. We strive to work efficiently to complete your needs in as few appointments as possible. This office has an excellent, highly trained and experienced staff, chosen so you will receive courteous and competent treatment. Our fee in exchange for this care is based on our time, material cost, experience, skill, care, and judgment, all directed toward rendering you and excellent result. We feel that everyone benefits when there is a definite and clear financial agreement prior to treatment. Treatment can be offered in a comfortable efficient manner. An estimate of your fee will be given at the consultation. To make your financial agreement as easy as possible for you we have the following methods of payment: we accept cash, checks, and credit cards. We also have partnerships with Cherry, Proceed, and Care Credit which are financial companies that finance dental treatment. You can apply for them directly through our website and [www.danosdental.com](http://www.danosdental.com).

If you have dental insurance, we will be happy to assist you in filing your insurance forms, but we ask that you pay using one of the methods listed above. If paying at the time of service is a hardship, please make prior arrangements with our Financial Administrator.

I hereby acknowledge that I have read and agree with this policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_