Mark T. Albers, D.D.S., 2155 Hollowbrook Drive, Ste. 20, Colorado Springs, CO 80918 (719) 634-8458

GENERAL INFORMATION

Patient's Full Name_____Prefers to be called_____

Address_____City/State_____Zip_____

Home Phone_____Cell Phone_____SSN_____DOB___/___/____

Occupation_____Employer_____Business Phone_____

Marital Status_____Name of Spouse_____Referred By_____

Emergency Contact_____Relationship to You_____Phone_____

Purpose of today's visit_____

We sincerely appreciate you coming to us for your dental care and we do our best to see everyone at the appointed time. Please understand that occasionally, circumstances such as dental emergencies can cause delays. You can help us to stay on time by **muting** your **cell phone** during your appointment to avoid interruptions in our care of you.

BILLING AND INSURANCE INFORMATION

Responsible party_____Relationship to Patient_____

Address if different from above_____City/State_____Zip_____

Place of Employment_____Business Phone_____

SSN Number_____DOB___/___/_____

Do you have dental insurance? Yes No

Policy Holder_____Policy/Subscriber#_____Group #_____

Insurance Company_____ Address_____

Dental Insurance: Although dental insurance is designed to reduce your cost, in many cases it does not cover the full cost of dental care. While we are happy to assist you in maximizing your dental benefits, the contract you have with your insurance company is between you and the company. Every contract is different and it is impossible for us to know what each individual has for coverage. If treatment is not covered in its entirety by insurance, payment of your deductible or co-payment is required at the time treatment is rendered. **The patient, or responsible party, is responsible for all fees charged by this office regardless of insurance coverage.**

Office Policy – Fees and Payment: As part of our goal to deliver the finest care possible at a reasonable cost to our patients, our office policy is that payment be made at the time of service for all treatment. A fee of **$35.00** will be applied for a returned check. On accounts over 90 days, a **1.5% service charge per month** will be applied. If your account is referred to a **collection agency**, you will be **required to pay an additional collection fee of 50% of the principal balance due plus all Court costs and reasonable attorneys' fees** incurred in connection with the collection of your account or any account where you are listed as the responsible party.

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Patient (or parent if minor) Signature Date