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 ___/___/_____

Marital Status_____Name of Spouse_____Referred By_____

Occupation_____Place of Employment_____Business Phone_____

Emergency Contact_____Relation to you_____Phone_____

Purpose of today's visit_____

We sincerely appreciate you coming to see us for your dental care. We will always try our best to see you at your appointed time. Please understand that on occasion, unforeseen circumstances, including dental emergencies, can cause delays.

BILLING AND INSURANCE INFORMATION

Responsible party_____Relationship to Patient_____

Address if different from above_____City/State_____Zip_____

Place of Employment_____Business Phone_____

SSN or ID Number_____DOB___/___/_____

Do you have dental insurance? Yes No Policy Holder_____ Policy/Subscriber #_____

Insurance Company_____Address_____

Fees and Payment: As part of our goal to deliver the finest care possible at a reasonable cost, we require payment at time of service for all treatment not covered by insurance. A fee of **$35.00** will applied for a returned check. On accounts over 90 days, a **1.5% service charge per** month will be applied.

Cancellations: When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at **719-634-8458** by **3:00 p.m.** on the **day prior** to your scheduled appointment to notify us of any changes or cancellations. To cancel a **Monday appointment**, please call our office by **3:00 p.m. on Thursday**. If prior notification is **not given,** you will be **charged $50.00** for the missed appointment.

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.**

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Patient (or parent if minor) Signature Date