PATRICIA J WEBB DDS

7221 Healdsburg Ave. Sebastopol, CA 95472 – (707) 823-6010

PATIENT

First name_____MI_____Last_____Today's Date_____

Home Phone_____Cell Phone_____Date of Birth_____

Mailing Address_____City/State/Zip_____

Email_____Social Security No._____

Name of School, if child_____Responsible party of child_____SSN_____

PATIENT'S EMPLOYER

Employer's name_____

Address_____

City/State/Zip_____

Phone_____

Occupation_____

PATIENT'S INSURANCE COMPANY

Company's name_____

Address_____

City/State/Zip_____

Phone_____

Group Policy #_____

SPOUSE

Name_____

Employer's name_____

Address_____

City/State/Zip _____

Phone _____

Occupation_____

SPOUSE'S INSURANCE COMPANY

Company's name_____

Address_____

City/State/Zip_____

Phone _____

Group Policy #_____

Spouse's SSN_____

Spouse's Birthdate_____

OTHER INFORMATION

Your physician_____City_____ Phone_____

Former Dentist_____ City_____ Phone_____

Reason for appointment_____ Date of last dental visit_____

Whom may we thank for referring you?_____

OFFICE POLICY

It is the policy of the office, after an examination is made, to provide you with an estimate for the necessary treatment. This will enable you, the patient, to know what treatment is planned and what the appointment cost will be. Payment for service is due at the time the service is rendered.

FINANCIAL POLICY:

-*Payment is due at the time of service*

-**Methods of Payment:** Cash, Check, Master Card, Visa, Discover, Care Credit

FOR PATIENTS WITH INSURANCE:

-*Deductibles and Co-payments are due at the time of dental treatment*

-As a courtesy, we will process your insurance forms at no additional cost to you. Please familiarize yourself with your insurance policy for waiting periods and limitations as plans differ. We are unable to guarantee payment from your insurance company. All fees for services are the ultimate responsibility of the patient. If your insurance company has not paid us within 90 days you will be asked to pay the balance and arrange with your insurance company for reimbursement. Interest charges will accrue to any overdue accounts at the rate of 1.5% per month.

FAILED APPOINTMENT: Please be advised there will be a charge for any missed or failed appointments that are not canceled or rescheduled within 2 business days.

Signature:_____ **Date:**_____