Patricia J. Webb, D.D.S.

7221 Healdsburg Avenue Sebastopol, CA 95472 • (707) 823-6010

PATIENT

First name _____ MI _____ Last _____ Today's date _____

Home phone _____ Social Security No. _____ Date of Birth _____

Home address _____ Mailing address _____

City / St / Zip _____ City / St / Zip _____

Name of school if child _____ Responsible party if child _____ SSN _____

PATIENT'S EMPLOYER

Employer's name_ _____

Address _____

City / St / Zip _____

Phone(__ _) _____

Occupation _____

PATIENT'S INSURANCE COMPANY

Company's name _____

Address _____

City / St / Zip _____

Phone(__ _) _____

Group Policy # _____

SPOUSE

Name _____

Employer's name _____

Address _____

City / St / Zip _____

Phone (___) _____

Occupation _____

SPOUSE'S INSURANCE COMPANY

Company's name_____ _____

Address _____

City / St / 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 this 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 approximate cost will be. Payment for services is due at the time the services are rendered.

Financial Policy:

Payment is due at the time of dental service.

Methods of Payment: Cash, Check, Master card, Visa, or 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. We will do everything possible for you to obtain the maximum benefit that your contract allows. However, all fees for service 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 account at the rate of 1.5% per month.

Appointment-keeping policy: Your commitment.

Should you need to reschedule your reserved time, we respectfully ask that you give 2 business days notice. This will allow my staff to offer this time to another patient.

Failed appointment fee: It ends up costing everyone.

It will be the policy of this office to charge for failed appointments at the rate of a normal office visit, $70.

Signed _____ Date _____