10404 Beardslee Blvd Bothell, WA 98011 (425)485-9557

Thank you for selecting our dental healthcare team**.** We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink (front & back). If you have any questions or need assistance, please ask us ~ we will be happy to help!

Patient Information (confidential) **Date** ____________**Social Security #** ___________________ **DOB** ___________

First _____________________MI_____ Last ______________________ Preferred _________________ **Male / Female**

Address__________________________________ Apt #_______City _______________State ______Zip ___________

Mailing Address If Different Than Above ____

Home # ______________________ Cell #______________________ **E-mail** ____________________________

Preferred Contact: Home / Cell / Work / Email / Text
Please Circle: Minor / Single / Married / Divorced / Widowed

Employer _________________________ Work# ______________________**Work E-mail** _________________________

If Student, Name of School/College _______________________________________ City & State _____________________

Whom May We Thank For Referring You? ____

In Case of an Emergency, name of a relative **NOT** Living With You ______________________ Phone ____________________

Responsible Party (if different than patient)

Name of Person Responsible For This Account ______________________________ Relationship To Patient _______________________

Address ____ Home # ________________ Work # _________________

Insurance Information

Name of Subscriber ____ Relationship To Patient _______________________

Social Security # _______________________________ Subscriber DOB _____________ Employer __________________

Name of Insurance Company _______________________Group # _________ Ins.Co.Phone # _______________________

Ins. Co. Address _____________________________________ City _____________ State ________ Zip ___________

DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Subscriber ____ Relationship To Patient ___________________

Social Security # ________________________________ Subscriber DOB __________ Employer ____________________

Name of Insurance Company ________________________Group # _________ Ins.Co. Phone #_______________________

Ins. Co. Address ______________________________________City______________ State ________ Zip ____________

Dental History

Reason For Today's Visit ____

When Was Your Last Dental Visit? ______________________ Previous Dentist's Name ______________

Have You Ever Had An Unfavorable Experience In The Dental Office? ______________________________

For restorative fillings, please circle your preference: **AMALGAM** (silver) or **COMPOSITE** (white)

For crown or inlays, please circle your preference: **GOLD** or **PORCELAIN**

Do you have any wisdom teeth? _____________ Have any of your wisdom teeth been taken out? __________

Our Office Policy

Our office is committed to providing you with the best quality of dental care. In order to achieve this goal, we need your cooperation as well as your understanding of this payment policy.

Payment for services is due at the time the care is provided, unless other arrangements are made with our Business Manager. We accept cash, checks, Visa and MasterCard.

A charge of $75.00/ hr is made for broken or cancelled appointments without 24 hours notice (excluding weekends and holidays). ____________
(Patient Initials)

Patient responsibilities regarding dental insurance:

If you have dental insurance, we will gladly submit claims for you; provided we are given complete and accurate insurance benefit information, as well as a release of benefits and information to your insurance company. We can estimate your insurance benefits for you, however we cannot guarantee payments. These estimates are based on your exams & x-rays. Changes in proposed treatment may need to be made due to clinical considerations. Your dental insurance is a contract between you and your insurance company; it is your responsibility to be aware of annual maximums and contract limitations. **All balances on your account are your responsibility. If your insurance company does not remit payment in 60 days, you will be responsible for the balance due in its entirety. We expect and appreciate payment of the "estimated" patient portion for your treatment at the time of visit.**

Authorization and Release

Permit for treatment and/or surgical care: I hereby grant permission to the staff of Sobczak-Wencel Restorative Dentistry to employ such established treatments and therapy as may be deemed professionally necessary and advisable.
Financial agreement: All charges for services and treatment will be paid upon completion of appointment. All outstanding balances shall accrue interest at the rate of 18% per annum. I authorize all credit inquiries deemed necessary in connection with my account.
Insurance: I hereby authorize payment directly to Sobczak-Wencel Restorative Dentistry of group benefits otherwise payable to me.
"I hereby certify that the above information is true and correct"

____ Date ______________
(patient or guardian's signature)