Welcome to Sunset Dental!! This letter is to acquaint our new patients with our general office policies to help avoid any misunderstandings. Our responsibilities are to you as our patient. We practice preventive dentistry and stress the importance of regular care to help you in your goal to achieve and maintain excellent dental health.

Insurance Patients: If you have dental insurance, it is your responsibility to bring a current insurance card to your appointment. We will file insurance claims as a courtesy to our patient. Remember that your insurance contract is between you and your insurer. It is your responsibility to be aware of insurance available for each treatment, any specific clauses stated in your policy, and deductibles and waiting periods. Insured patients should be prepared to pay their co-pay and/or deductible at time of service. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance will be due upon receipt of your statement. It is also your responsibility to make sure that we are a listed provider with your insurance company.

Patients with no Insurance: Patients with no insurance are required to pay for their treatment in full at the time of service, unless other prior arrangements are made.

Payment: We honor Visa, MasterCard, Cash and Personal Checks with proper identification. Checks written with insufficient amount will have accounts billed $50.00 for each bad check. Statements will be sent out on a monthly basis.

Delinquent Accounts: Any fees, such as Attorney's fees, collection agency fees and court costs incurred as a result of overdue accounts will be the patient's complete financial responsibility.

We try to see our patients as promptly as possible. However, there are times when emergencies and/or surgeries may arise causing unavoidable delays.

We ask that our patients please give us at least 24-hour notice when canceling an appointment. These times are reserved for you. Failure to give notice on multiple occasions will result in a broken appointment charge.

Our goal is to make your appointment as comfortable, safe and pleasant as possible. If you should have any questions or suggestions, please feel free to discuss them with our doctor and staff.

By signing on the line below I am stating that I have read or have had it read to me and I understand my responsibilities listed in the above policies.

_____ _____

Patient or Guardian's Signature Date

Patient Information (confidential)

Patient ID #_____
SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Work Phone_____ Cell Phone _____

Check Appropriate Boxes: ☐Male ☐Female ☐Minor ☐ Single ☐ Married ☐Divorced ☐ Separated

If Student, Name of School/College_____ City _____ ☐part-time ☐full-time

Patient's or Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____

Spouse or Guardian's Name _____ Employer _____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to contact in case of emergency _____ Phone _____

is this person currently patient in our office? ☐ *Yes* ☐ *No*

Responsible Party

Name of Person Responsible for this account _____ Relation to Patient _____

Address_____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#_____

Dental Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____ Email _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Financial Policy

All patients please read the following...

Payment is expected for all services at the time the service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, MasterCard and Visa are accepted. If an extended payment is desired, please ask us about the Care Credit program.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable financial charges and disbursements, allowances, and cost provided by law shall be included in the computation of the amount due.

Finance charges may be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of the insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

We do not accept Medicaid or NC Choice

_____

Patient / Guardian Signature

_____

Date

SUNSET DENTAL

688 SUNSET BLVD N

SUNSET BEACH NC 28468

910-575-6300 (PHONE) 910-575-6311 (FAX)

PATIENT RECORD RELEASE FORM

Name of Person Whose Records Are Requested:_____

DOB: _____

Phone Number: _____

PLEASE PROVIDE A COPY OF RECORD MARKED BELOW

_____ **XRAYS**

_____ **A SPECIFIC DENTAL RECORD IF AVAILABLE**

PLEASE EMAIL RECORDS TO : SUNSETDENTAL@ATMC.NET

Previous Dentist Information:

Name of Previous Dentist:_____

Address: _____

Phone:_____ Fax: _____

Email:_____

_____ _____

SIGNATURE OF PATIENT DATE