Welcome!

How did you hear about us? _____

Patient Information

Name:_____ Birthdate:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Home # :_____ Cell # :_____ Work #:_____

Email:_____ Drivers License:_____

Marital Status: Minor _____ Single _____ Married _____ Divorced _____ Widowed _____

If Student: Name of School:_____ Full Time _____ Part Time _____

Responsible Party

If patient is a minor: Name of person responsible for the account: _____

Address:_____ City: _____ State:_____ Zip:_____

Home:_____ Cell: _____ Work: _____

Relationship to Patient: _____ Birthdate: _____ SSN:_____

Drivers license:_____ Employer: _____

Dental Insurance Information

Name of Insurance Company: _____ Phone Number:_____

Address:_____ City:_____ State: _____ Zip:_____

Policy Holder:_____ Birthdate: _____ SSN:_____

Member ID Number:_____ Employer:_____

Additional Insurance Company:_____ Phone Number:_____

Address:_____ City: _____ State:_____ Zip:_____

Insured's Name:_____ Birthdate: _____ SSN:_____

Member ID Number:_____ Employer:_____

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance within 60 days.

Patient (Or Guardian's) Signature_____ Date_____

Office Policies

nsurance

You, as the patient, are responsible for all charges regardless of insurance coverage. It is your responsibility to know your insurance benefits, frequencies, and limitations. However as a courtesy to our patients, we will file your dental insurance for you. We are providers for many insurance companies; therefore we accept the reduced fee in which they allow us to charge. Please keep in mind that when we inquire the verification and/ or pre-determination of benefits, nothing is guaranteed. It is only an estimate until the insurance company reviews the claim. We will do the best to our ability, to provide the insurance company all information needed to get the claim paid. There are times however when a dental claim goes to a dental review board for consideration. It is within the review boards' discretion to accept or deny the claim. If the claim is denied, then the patient is responsible for payment. You as the insured have to right to appeal, but at that point when we have exhausted all our means, we cannot get involved and the balance must be paid in full by the patient.

Payments

As a courtesy to our patients we accept most major credit cards and checks with proper identification. We do not accept posted dated checks. There will be a $25.00 charge on all returned checks, and the balance must then be paid in full in cash or money order only. Patients that have an outstanding balance of 30 days or more overdue are subject to 1.5% monthly interest, as addition to collection fees, court costs, and reasonable attorney fees to collect unpaid accounts. Patients with such outstanding balances must make payment arrangements prior to scheduling appointments. If treatment needs to be performed and your total estimate has been advised, we do expect payment at the time of treatment.

Confirming/Cancelling Appointments

You will receive a text and/or email reminder regarding appointments. Please confirm or cancel your appointment by responding to this email/text or calling our office at 210-828-6357. You will receive an email and text from Lighhouse. Please confirm or cancel your dental appointment upon receipt of this message.

Missed Appointments/Non 24 Hour Cancellation/Late Arrivals

Clint A Clements DDS does have a, $50 per hour, policy for No Show/Non 24 Hour Cancellations. Due to the unfortunate influx of no shows we have to enforce this policy. We do not double book our patients and reserve this time just for you. When someone doesn't show up our staff sits with nothing to do but are still being paid. If you cannot give 24 hour notice please call us and let us know. We will certainly do our best to fill the appointment slot, the more notice you give us the better the chance we will have in filling it. If we can fill the slot the fee will then be reversed. If we fail to fill it unfortunately the fee will stand. If you are running late for an appointment please let us know. If you are more than 15 minutes late, your appointment could possibly be rescheduled to another day and a fee could be charged.

Patient (Or Guardian) Signature _____ Date _____

Informed Consent

General Consent Form

I understand that there are substantial risks and consequences that may be associated with any surgical, dental or anesthetic procedures. I understand every conceivable hazard cannot be listed. I realize the following possibilities exist, however infrequent or rare.

1. Local Anesthetic

- Allergic reaction, hives, shortness of breath.
- Fainting, dizziness, rapid heart rate.
- Hematoma (internal and/or external bruise).
- Soreness at injection site.
- Biting of tongue, lip, or cheek.
- Paresthesia (temporary or permanent numbness of lip or tongue).
- Broken needle.

2. Amalgam And/Or Resin Fillings And/Or Sealants

- Possible sensitivity to hot and cold for several weeks.
- Sometimes tooth can abscess and require root canal and crown at additional fee.
- Bite adjustment may be needed after insertion.
- Resin(s) and sealant(s) will stain.
- Amalgam(s), resin(s), and sealant(s) may need replacements at a future date at an additional cost.
- Gum irritation.

I also understand that other different conditions may be discovered which require additional or different procedured from those planned may involve additional fees.

I am aware that it is my responsibility to understand the recommended treatment, the fee(s) involved, the risks of treatment, any alternatives and risks of these alternatives, including the consequences of doing no treatment at all. I will have all of my questions answered prior to treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Doctor Signature _____ Date _____