Welcome

M. SCOTT UPDYKE D.D.S.
GENERAL DENTISTRY

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. If you have any questions or need assistance, please ask us, we will be happy to help.

M. Scott Updyke, D.D.S.

PATIENT INFORMATION

Patient's Name _____ Spouse's Name _____

Responsible party of child: Name _____ ❑ Mother ❑ Father ❑ Legal Guardian

If student, age 18 or over, name and address of school _____

_____

Home Address _____
STREET CITY STATE ZIP

Telephone: Home: _____ Work: _____ Cell: _____

Patient's Birthdate ____/____/____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Separated

E-Mail Address _____

Emergency Contact: _____ Telephone: _____

Who introduced you to our office: _____

DENTAL INSURANCE INFORMATION

Insurance policies are contracts between you and the insurance company. To avoid misunderstandings regarding dental insurance, our professional services are charged directly to you and you are personally responsible for payment of fees.

WHAT WE DO:

- Prepare a request for predetermination of benefits, on larger cases, so that you can anticipate what your insurance will pay.
- Prepare and mail the claim form.

WHAT WE EXPECT OF YOU:

- Provide complete and accurate information of your insurance - Advise us of any changes to coverage or other pertinent information.
- Either, 1) Pay your approximate portion when treatment begins, 2) Pay your balance in full when your insurance pays, but no longer than 30 days from date of treatment, or 3) make monthly payments towards your share STARTING WITH YOUR FIRST STATEMENT OR YOUR CONTRACT DATE.
- Contact your insurance or employer if payment is not received within 90 days of treatment.
- Forward to us insurance checks that are sent to you if you have a balance due.

Insured Employee _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Relationship to Employee _____ Group/Policy Number _____ Union Number _____

Employer _____

Insurance Company (1) _____
ADDRESS CITY STATE ZIP

COMPLETE SECOND SECTION ONLY IF COVERED BY TWO INSURANCE COMPANIES

Insured Employee _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Relationship to Employee _____ Group/Policy Number _____ Union Number _____

Employer _____

Insurance Company (1) _____
ADDRESS CITY STATE ZIP

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