S&C DENTAL

17767 N Scottsdale Rd Ste #110
Scottsdale, AZ 85255
(480)691-0020
www.snc.dental

Who may we thank for referring you to our office? _____

Patient Information

Patient Name _____

Mailing Address_____

City _____State _____ Zip _____

Social Security #_____ Date of Birth _____ Gender _____

Cell Phone _____ Work Phone _____Home Phone _____

E-Mail _____ Marital Status _____ Spouse Name _____

Occupation _____ Employer _____

Emergency contact _____ Relationship _____ Phone _____

Dental Insurance Information

Primary Dental Insurance:

Subscriber's Name _____ Date of Birth _____

Subscriber's Social Security # _____ Employer _____

Dental Insurance Company _____

Subscriber ID # _____ Group # _____

Secondary Dental Insurance:

Subscriber's Name _____ Date of Birth _____

Subscriber's Social Security # _____ Employer _____

Dental Insurance Company _____

Subscriber ID # _____ Group # _____

If you have a third insurance plan please attach details

S&C Dental Office Policy

Welcome to S&C Dental! We are here to provide our patients with the best possible dental care. As your provider, we recommend treatment that is in the best interest of your medical and dental health. Be aware that insurance companies select certain dental procedures that they may or may not cover regardless of your personal situation, health, and dental needs. The following is an overview of our office financial policy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. **Initials** _____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays**.** **Initials** _____

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Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard and Discover. Our office also offers no interest and extended payment plans, upon approved credit, through CareCredit. **Initials** _____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances may not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed, as necessary. **Initials** _____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in S&C Dental being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. **Initials** _____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48-hour notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00. We understand emergencies arise; we are sensitive to those events. **Initials** _____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to S&C Dental. **Initials** _____

Responsible party signature _____ **Date** _____

Name of Person Responsible for Account _____

Patient Name (if different) _____**Relationship to patient** _____