HOLT Family & Cosmetic DENTAL CARE

**Holt Dental Care**
**James H. Holt D.D.S., PA**

**Comprehensive Aesthetic Dentistry and Orthodontics**

## Creating Beautiful Smiles with Today's Technology!

### Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____

E-Mail: _____ Cell: _____ Fax: _____

Address: _____
Street Apartment #

_____
City State Zip Code

### Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Dental office
☐ Yellow Pages ☐ School ☐ Work ☐ Internet _____ ☐ Other _____

Name of person or office referring you to our practice: _____

### Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birthdate: _____ Driver's License: _____

Phone (Home): _____ Work _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

### Employment Information

The following is for: ☐ the patient ☐ the person responsible for the account

Employer's Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

## Insurance Information

Name:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ Social Security #:_____ Group#:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Telephone:_____

# Dental Treatment Consent Form

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I understand that Holt Dental Care cannot guarantee any estimated dental coverage. I understand that insurance is a contract between me and my insurance company. Holt Dental Care is NOT a party to this contract, in most cases. Holt Dental Care will bill your primary insurance company as a courtesy for patients. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility. I agree to pay any portion of the charges not covered by insurance. If my insurance company requires a referral and/or pre-authorization, I am responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company. **If for some reason my insurance has not paid their portion within 60 days from the start of treatment, I am responsible for payment at that time. Finance charges will be assessed on accounts over 90 days.**

5. FOR YOUR INFORMATION, PLEASE READ OFFICE POLICY:
WE WOULD LIKE YOU TO BE INFORMED ABOUR POLICIES. Please take a few moments to read and acknowledge this:
**FIXED OR REMOVAL PROSTHETICS**, such as dentures, crowns, bridges, or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made.
**AS A COURTESY TO YOU,** Holt Dental Care will, if necessary, accept 50% of this amount at the time of the impression. The balance must be paid at the time of permanent seating, or no more than 30 DAYS from date of impression, WHICHEVER COMES FIRST, unless prior arrangements have been made with our Office Manager. We accept insurance for payment; however, you must pay your portion at the time services are rendered.
**PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOU COMFORT, AND PROPER FIT.** If you fail to have your prosthetics seated within 60 days from the date of impression, and a second impression must be made, you will be charged an additional amount of one-half of our current charge of such procedure.
**WE OFFER YOU QUALITY DENTAL CARE, ECONOMICALLY PRICED**, and we want you to feel comfortable with all our treatments and policies. Please feel most welcome to contact our office manager for any questions you may have.

Patient's signature:_____ Date:_____ Witness:_____

Parent or Guardian:_____ Relationship to Patient:_____