Welcome to Df2ōl·f {Y'ĺfŜă!

So that we may better serve you, please indicate the purpose of your visit today:

Are you interested in any of the following services?

- ☐ Replacing missing teeth?
- ☐ Dental Implants?
- ☐ Straightening your teeth?
- ☐ Invisalign, the process of straightening your teeth without braces?
- ☐ Whitening your teeth?
- ☐ Closing spaces between your teeth?
- ☐ Changing the shape of your teeth?
- ☐ Fixing food trap areas?
- ☐ Conscious sedation dentistry?

Please tick your dental anxiety level.

(NO Problem) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 (Fear Beyond Belief)

Patient Signature: Date:

PATIENT INFORMATION

Please Print Legibly, Thank You.

1. • _____ • _____
Patient's Name Preferred Name

2. • _____ • _____ • _____ • _____
Mailing Address (include apartment #) City State Zip

3. • _____ • Sex: ○ M ○ F _____ • _____ • _____
Patient DOB Social Security # Drivers License # State where Issued

4. • _____ • _____ • _____
Home # Cell # E-mail Address

5. • _____ • _____ • _____
Your Employer's Name Job Description/Title Work #

6. • _____ • _____ • _____ • _____
Employer's Address (include suite #) City State Zip

7. • _____ • _____ • _____
Person to Call in Case of Emergency Relationship Phone #

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

PRIMARY DENTAL INSURANCE INFORMATION

1. • _____ • _____ • _____ • _____
Insurance Company Name Ins. Phone # Group # Union #

2. • _____ • _____ • _____ • _____
Insurance Company Address City State Zip

3. • _____ • _____ Sex: ○ M ○ F
Policy Holder's Last Name First Name M.I. DOB

4. • _____ • _____ • _____ • _____
Policy Holder's Mailing Address City State Zip

5. • _____ • _____ • _____ • _____
Policy Holder's Home # Work # Cell # Policy Holder's Social Security #

6. • _____ • _____ • _____ • _____
Policy Holder's Employer Name Job Description/Title Drivers License # State where Issued

7. • _____ • _____ • _____ • _____
Policy Holder's Employer Address City State Zip

I understand that regardless of my dental insurance status, I am ultimately responsible for the balance of my account for any professional services received. I certify the information that I have provided on this form is true. I will notify Global Smiles of any changes in the above information as soon as I am aware.

X _____ _____ _____
Signature of Patient Date Guardian if Under 18 Years of Age) Date

Assignment of Benefits

Name: _____

I hereby instruct and direct my dental insurance provider to pay my dentist (Global Smiles) for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered; by check, made out and mailed to:

Dr. Lilliana Stojic DDS, MAGD

1801 Professional Drive

Sacramento, CA 95825

If my current policy prohibits direct payment to my dental provider, I hereby instruct and direct my dental insurance provider to make the check out to me and mail it to the following address:

Dr. Lilliana Stojic DDS, MAGD

1801 Professional Drive

Sacramento, CA 95825

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The insurance payment(s) will not exceed my indebtedness to Global Smiles, and I have agreed to pay any balance of professional service charges over, above, and not covered by the insurance payment(s).

A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize the release of my personal information to any insurance company, adjuster, or attorney involved with my dental care.
If necessary, I authorize Global Smiles to initiate a complaint to the State Insurance Commissioner(s) for any reason on my behalf.

Signed at (City) _____ on (Date) _____

Signature of Patient (or Guardian if Under 18 Years of Age): _____

Witness: _____

OFFICE POLICY

PATIENTS WITH DENTAL INSURANCE: As a courtesy to you, our office will gladly submit rendered services to your --- _____ insurance. We are able to bill to all traditional insurance plans. We **DO NOT** participate with DMO or HMO plans. Under these plans, there is **NO COVERAGE** when treatment is rendered by a non-participating dentist. Please check your type of plan carefully.

PATIENTS WITH DELTA DENTAL INSURANCE: Dr. Lilliana is a "**PREMIER"** provider (not PPO). However, we are still able to bill your insurance for all PPO plans, even though Dr. Lilliana is out-of-network.

AUTHORIZATION TO RELEASE INFO AND ASSIGNMENT OF BENEFITS:I certify that - _____ _____I_____, (or my dependent) have(has) dental insurance coverage and assign directly to Dr. Lilliana Stojic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment benefits.

PAYMENTS: We accept cash, check, Visa, MasterCard, and Discover. Payment of your "estimated" portion is due at the time _____services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot *guarantee* the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

UNPAID INSURANCE CLAIMS: All dental services rendered, whether or not covered by your insurance, are ultimately the _____financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, the balance will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive payment from your insurance after it has been paid by you, a prompt refund will be issued.

PAST DUE ACCOUNTS: If payment is not received by the due date printed on the statement, then your account is considered _____"past due". We reserve the right to charge a $10.00 per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collections agency and/or our attorney for collection, the account holder will be responsible for ALL attorney fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

PATIENTS WITHOUT DENTAL INSURANCE: Payment in full is expected at the time services are rendered. We accept _____cash, check, Visa, Mastercard, and Discover.

BROKEN/ MISSED APPOINTMENTS: We request at least 48 business hours' notice before cancelling or rescheduling an _____appointment. Less than 48 business hours make it difficult for us to fill the opening left in our schedule. Friday, Saturday and Sundays are not considered business hours. We reserve the right to charge your account $50 per hour reserved for the appointment if not notified.

Dr. Lilliana reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Responsible
Party Signature: _____ Relationship to patient: _____