White Clay Dental Associates, P.A.

12 POLLY DRUMMOND HILL ROAD
NEWARK, DE 19711-5703
302-731-4225

PATIENT INFORMATION

Name_______________________________________Nick Name______________________

How would you like to be addressed? (please circle one)

Dr. (PhD, MD, other _________) Mr. Mrs. Miss Ms. first name nick name

Home Address____

____ ZIP____________________

Employer ____

Employer's Address ____

____ ZIP____________________

Home Phone Number ___________________ Business Phone Number__________________

Male Female Date of Birth___________________________

Social Security # of Patient____

PRIMARY DENTAL INSURANCE (you may use "same" if patient is employee)

Employee________________________________ Date of Birth________________________

Social Security#______________________ Employer_____________________________

Insurance Company Name and Address____

____

Group Plan Name____

Group Number_______________________ Agreement Number_________________________

SECONDARY DENTAL INSURANCE

(Complete only if you have two dental insurance coverages)

Employee________________________________ Date of Birth________________________

Social Security#______________________ Employer_____________________________

Insurance Company Name and Address____

____

Group Plan Name____

Group Number_______________________ Agreement Number_________________________

HEAD OF HOUSEHOLD____

Person to bill if not head of household____

Who referred you to our office?____

What other relatives are patients in our office?

____

- -

for office use: patient number__________________ date__________________

Patient Financial Policy for White Clay Dental Associates, P.A.

Self-Pay Accounts

Self-pay accounts are patients who are not covered by insurance. Payment is required at the time of service unless other financial arrangements have been made prior to treatment. Various payment plans are available and a 3-5% discount is given when payment is made in full at time of service. We accept VISA, MasterCard, Discover and several third-party financing options (i.e. Care Credit).

Insurance

As a courtesy, we will submit dental claims on your behalf. All estimated out-of-pocket costs are due in full at time of service unless other financial arrangements have been made prior to treatment. Any charges not covered by insurance are the patient responsibility. Patients are ultimately responsible for knowing their dental benefits, including frequency limitations, deductibles and maximums. We are available to assist you with obtaining this information.

If insurance company pays the patient directly, it is expected the check will be given to White Clay Dental Associates within 30 days of issue. Failure to do so will result in the patient needing to pay in full at time of service and being reimbursed by the insurance company.

Broken or Failed appointments

Your scheduled appointment has been reserved at your request. Cancellations with less than 24 hours notice may result in a broken appointment charge commensurate to the length of appointment time reserved. White Clay Dental offers many ways to be reminded of your appointments including phone calls, text and e-mail reminders.

Past Due Accounts

Past due accounts will be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account.

Non-Sufficient Funds

There is a $30.00 fee for any item returned due to non-sufficient funds.

Child Custody Cases

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the practice for care. The custodial parent is responsible for all estimated out-of-pocket costs at the time of service. If the non-custodial parent carries the insurance on the child, the practice will bill that insurance company. The practice does not get involved with divorce specifics, e.g., one parent pays 80% and the other 20%. It is the parent's obligation to work out an agreement themselves.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please do not hesitate to contact us.

Signature_____ Date_____

White Clay Dental Associates

Dear Patients,

To better communicate with our patients we are asking for your e-mail address and cell phone numbers.

This information will allow us to e-mail and or text appointment reminders or other communication in the future. Your information will not be shared with anyone or any company.

Our goal is to serve you more efficiently and be more accommodating to our patients.

Thank you for your cooperation in this matter.

Donald Bond, D.D.S.
Timothy Ganfield, D.M.D.

Name

e-mail

cell phone

Name

e-mail

cell phone

Name

e-mail

cell phone