Timothy M. Blair, D.D.S
www.gentledentistry.info
500 Lentz Drive, Suite 90
Madison, Tennessee 37115
615-865-7176 615-865-5066 (facsimile)

Who referred you to Dr. Blair?

____

REFER A FRIEND

We appreciate your referrals, and as a way of saying thank you for your confidence, we will send you a $25 gift card for each friend or family member you recommend to our practice.*

Ask about our monthly drawing for a one night stay for two people at the Marriott Nashville at Vanderbilt University!

Patient Registration Form

(Please complete and bring these forms to your appointment)

____

First Name **Middle Initial** **Last Name**

____

Address **City, State, Zip**

____________ ____________ ____________ ____________

Home Phone **Cell Phone** **Work Phone** **Other Contact Number**

____________ ____________ ________________________

Birth Date **Social Security** **Driver's License (we will photocopy)** **State issued**

Please circle: MALE FEMALE Marital Status: Married Single Divorced Widowed

Email: ______________________________ Okay to contact via email: Yes No

In case of emergency, call __________________ Relationship to patient __________________

Phone number __________________ Alternate phone number __________________

Insurance Information *(Please circle)*

Do you have dental insurance? YES NO If YES, please complete the Insurance Information form.

How will you pay for today's visit? Check Cash Credit Card

I am interested in a payment plan and would like information. YES NO

CareCredit is available to you and an application can be accessed on our website or a copy provided to you at the office.

Financial Policy

I understand and agree that Dr. Blair files insurance as a courtesy and only I am ultimately responsible for the balance of my account after any insurance pays for services rendered. My patient portion of payment is due at the time services are rendered. Should any unforeseen problems arise with my account, and my account becomes past due, I am aware that I will be charged 1.37% interest monthly. If it becomes necessary to turn my account over to a collection agency, I agree to pay attorney and collection fees to satisfy the account.

______________________________ ______________________________

Authorized Signature Date

(Please continue to the next page)

*Gift cards are mailed after referred patient is seen in our office and referring patient's account has zero balance.

INSURANCE INFORMATION

Please be advised that we file insurance as a courtesy. Expenses incurred in our office are the responsibility of the patient, not the insurance company. Should your claim be denied, payment in full is due immediately. Furthermore, if your insurance company has not responded to our claim within 45 days from the date of service, the entire balance will be transferred to you, the patient, for immediate payment.

Primary Insurance Information:

______________________________ ______________________ ____________
Patient Name Patient Date of Birth Age

____
Name of Insured **Insured Social Security** **Insured Date of Birth**

Relation to patient: Self Spouse Child Other

____
Employer

____
Employer Address **City, State, & Zip:**

____
Insurance Name **Insurance Address** **Insurance Phone Number**

____
Insurance Number **Group Number**

If patient is a student over the age of 18 years, please complete:

School Attending: ____

City and State: ______________________________ ___ Full time ___ Part-time

It may be necessary for you to provide, direct to your insurance company, proof of student status in order to process any claims.

Assignment of Benefits: I hereby authorize payment direct to Timothy M. Blair, DDS, for all dental service performed. I authorize the processing of my insurance claim via electronic transmission. I understand that my insurance coverage is based on a contract between the insurance carrier and my employer. Dr. Blair and his associates cannot be held responsible for changes in coverage, maximum limits and non-covered procedures.

___________________________ ____________________________________ __________________
Print Name Authorized Signature Date

Office Use Only:

Prev: __________ Basic: _____________ Major: _____________ Ded: ______________ Max: ______________

Effective Date: ____________ Calendar Year? Y N Waiting period: _________ Missing Tooth Clause _______

Insurance Notes:

Timothy M Blair, D.D.S
Gentle Dentistry
How Dental Insurance Works

Dental insurance is offered to employees or members through companies, unions, and associations. Dental benefits vary from one plan to the next. Dental insurance is not the same as medical insurance that helps you when a catastrophe occurs or you need surgery. Dental insurance PROVIDES a "Defined, Limited" benefit.

Who decided which benefits are covered in your dental plan? Your employee coverage depends upon the premium paid for coverage; low premiums tend to have fewer benefits. Plans may cover 50% to 80% of the cost of dental services, some plans cover as little as 30%, other plans up to 100% of dental fees. Plans will offer a full range of dental treatment, other plans exclude services such as dental implants, orthodontic care or even periodontal surgery.

Plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. You may receive less reimbursement than your dental plan appears to promise; for example, if your plan pays 80& of the cost of dental treatment, it means 80% of the fee chosen by the insurance company, not the actual fee charge by your doctor. Most dental plans have an annual maximum that vary, customarily it is $1,000 to $1,500. Once you reach your maximum amount for the year, your insurance company will pay nothing regardless if the procedure is covered or not covered.

Another way dental plans differ is the freedom to choose your own dentist. Some plans require you receive care from a limited number of dentists. Because we value our relationship with patients, we believe you should have the right to seek care from the dentist of your choice.

Each treatment plan we present is unique for you and will be determined by your dental needs and general health, not your dental benefit plan. We believe it is not in your best interest to compromise your treatment to fit an insurance program's benefits. All treatment plans are discussed with the patient prior to treatment.

We file dental insurance as a courtesy to you. It is your responsibility to provide us with all the necessary information; insurance card. Prior to your appointment, a staff member will review the treatment you are to receive, the charges, what your insurance will pay and your financial responsibility. Your portion of the payment is expected on the day of treatment. For your convenience, we offer CareCredit financing that provides several payment options.

I have read "How Dental Insurance Works"

____	______________________________________
Patient's name (please print)	Patient's Signature (or Parent or Guardian)

Date ____________________