DENTAL SPECIALISTS &
IMPLANT CLINIC OF IOWA
PERIODONTICS | ORAL & MAXILLOFACIAL SURGERY | ENDODONTICS

LYELL R. HOGG, DDS
AARON J. KOTECKI, DDS
GRACE S. MOORE, DDS, MS
GREGORY C. GELL, DDS, MS

General Patient Information

First Name:_____ M.I._____ Last Name:_____

Nickname: _____ Sex: ❒ M ❒ F S.S. #:_____ Age:_____ DOB: _____

Street _____ City: _____ State:_____ Zip:_____

Home Ph:_____ Cell Ph: _____ Have you ever been a patient of our practice? ❒ Yes ❒ No

Email:_____ Employer:_____ Bus. Ph:_____

PERSON LEGALLY RESPONSIBLE FOR ACCOUNT (IF UNDER 18)

Who will be responsible for your account? ❒ Self ❒ POA ❒ Spouse ❒ Father ❒ Mother ❒ Other:_____
(if self, skip next section)

Name _____ S.S. #:_____ DOB: _____ Ph:_____

Street _____ City: _____ State:_____ Zip:_____

Employer_____ Bus. Ph:_____

❒ **NO DENTAL** ❒ **NO MEDICAL**

Primary Dental Insurance

Subscriber: _____

Relation:_____

Sex: ❒ M ❒ F DOB: _____

Insurance Co.:_____

Insurance Co. Address:_____

_____

Phone: _____

S.S. # _____

Employer:_____

Group: _____

Member ID:_____

Secondary Dental Insurance

Subscriber: _____

Relation:_____

Sex: ❒ M ❒ F DOB: _____

Insurance Co.:_____

Insurance Co. Address:_____

_____

Phone: _____

S.S. # _____

Employer:_____

Group: _____

Member ID:_____

Primary Medical Insurance

Subscriber: _____

Relation:_____

Sex: ❒ M ❒ F DOB: _____

Insurance Co.:_____

Insurance Co. Address:_____

_____

Phone: _____

S.S. # _____

Employer:_____

Group: _____

Member ID:_____

Secondary Medical Insurance

Subscriber: _____

Relation:_____

Sex: ❒ M ❒ F DOB: _____

Insurance Co.:_____

Insurance Co. Address:_____

_____

Phone: _____

S.S. # _____

Employer:_____

Group: _____

Member ID:_____

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Financial Policy

Thank you for selection Dental Specialist & Implant Clinic of Iowa as your personal dental care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. If you have any questions concerning our financial policies, please do not hesitate to ask!

PAYMENT IS DUE AT THE TIME OF SERVICE:

We accept cash, personal checks, Visa, Mastercard, American Express and Discover. When insurance applies, we will collect any deductible and estimated co-payment at the time of service for our In-Network providers. For our Out of Network providers, payment is due in full.

As a courtesy to our patients, we will file insurance claims for you with the information you provided; however, our professional services are rendered to you and not to the insurance company. Therefore, you are directly responsible to us for the cost of your treatment.

Medicare:

We do not accept assignment of Medicare benefits. Upon request we can provide documentation for you to seek reimbursement for services provided.

Financing:

Patients wishing to finance treatment fees may be eligible for payment plans/financing through CareCredit. We are pleased to offer:

- $200-$599 6 months interest free
- $600+ 12 months interest free
- $20,000 18 months interest free

Confirmation Policy:

When we schedule your appointment, the time is reserved exclusively for you. We kindly request notice as soon as possible. If you cannot keep your appointment and notify us less than 72 hours ahead of time, you may incur a missed fee of $50.00.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse, my parent and/or employer.

Signature:_____ Date:_____