SWISS BIOLOGIC DENTISTRY
4202 North 32nd Street, Suite A
Phoenix, Arizona 85018
p: 602.956.4800 | f: 602.903.7228
dental@swissbiologic.com | swissbiologic.com

Patient and Insurance Information

Patient Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss _____

Address: _____

City: _____ State: _____Zip: _____

Mailing Address (if different from above): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Phone: **[ ]Home [ ]Work [ ]Cell** Email: _____

☐ **Yes** ☐ **No** I give permission to Swiss Biologic Dentistry to leave my personal dental information (i.e. treatment plans, ledger/statements, questions or concerns regarding treatment etc.) on the answering machine and/or email address listed above, Initial_____.

☐ **Yes** ☐ **No** I give permission to Swiss Biologic Dentistry to share my personal dental information (i.e. treatment plans, ledger/statements, x-rays, medical history, etc.) with anyone on my family file, or the following named persons _____, Initial _____.

Date of Birth: _____ Social Security Number: _____

Employer: _____

If full time student, name of school: _____

Name of person responsible for account: _____

Address/ Phone (if different from above): _____

Name of Spouse/Partner: _____

Spouse/Partner's Employer: _____

Emergency Contact: _____

Relationship: _____ Phone: _____ Address: _____

How did you hear about us? _____

By what name do you prefer to be called? _____

Your Preferred Pharmacy _____ Phone _____

Pharmacy Address _____ **or** Pharmacy Cross Streets _____

INSURANCE INFORMATION

First Insurance Company: _____ Effective Date: _____

Address: _____

Policy/ Subscriber Name: _____ Employer: _____

Member ID: _____ Birthdate: _____ Group Policy#: _____

Relation to Patient: ☐Self ☐Spouse ☐Child ☐Other

Second Insurance Company: _____ Effective Date: _____

Address: _____

Policy/ Subscriber Name: _____ Employer: _____

Social Security#/ Member ID: _____ Birthdate: _____ Group Policy#: _____

Relation to Patient: ☐Self ☐Spouse ☐Child ☐Other

FINANCIAL AGREEMENT
I understand that all responsibility for payment for dental provided in the office for my dependents or myself is mine, due and payable at times services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon date. I understand that a 1.5% finance charge (18% APR) may be added to my account.

INSURANCE FILING
You, the patient, are ultimately responsible for payment in full on your account, not the insurance company.
We will file dental benefit claims as a courtesy to our patients; however, we can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. Some insurance companies arbitrarily select certain procedures they will not cover. In the event your insurance company does not pay or does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF DENTAL BENEFITS
I/we hereby assign directly to Swiss Biologic Dentistry insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for the changes not paid by this assignment.

COLLECTION PROCEEDINGS
In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees. In addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS
I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give this office notice **two (2) business days prior to my scheduled appointment. This office reserves the right to charge for missed appointments at $100 per hour for each scheduled hour missed.**

RETURNED CHECKS
I understand that there will be a $35.00 insufficient funds fee added to my account in the event of a returned check.

ARBITRATION
I understand that any dispute as to medical services, or any other issue arising out of services rendered by Swiss Biologic Dentistry, LLC's staff or third-party contractors, will be determined by submission to arbitration as provided by Arizona law, and not by lawsuit or court process, except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this agreement give up their right to have any such dispute decided in a court of law before a jury, and instead accept the use of binding arbitration.

CHANGE OF INFORMATION
I understand that it is my responsibility to advise this office of any change in the information I provide regarding my insurance, patient information, contact information, or the health history form.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have received a copy of this office's Notice of Privacy Practices.

PATIENT DISMISSAL
I understand that there are grounds for immediate dismissal as a patient from Swiss Biologic Dentistry if any offenses are committed; these offenses include, but are not limited to: rude or abusive behavior toward any staff member, non-compliance with treatment plan, medication misuse, multiple missed office visits, failure to pay on account.

_____ _____
Signature of Patient/Parent or Guardian Date