

# Hillcrest Dental Associates, P.C.

220 Hillcrest Drive

**K. Michael Garrett, D.D.S.**

Today's Date \_\_\_\_\_

Mr. \_\_\_\_\_  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_  
Patient's Last Name      First Name      Initial      Birthdate \_\_\_\_\_      Age \_\_\_\_\_      Soc. Sec. No. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_

Person Financially \_\_\_\_\_ Relationship \_\_\_\_\_  
Responsible \_\_\_\_\_ To You \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Driver's Lic. No. \_\_\_\_\_ Fax # \_\_\_\_\_ E-mail Address \_\_\_\_\_

How did you hear about our office?     Relative/Friend     Phone Book     Advertisement     Other \_\_\_\_\_

## Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Group# (Plan, Local or Policy#) \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Group# (Plan, Local or Policy#) \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## Financial Policy: Payment Options

Our mission is to deliver the finest, most cost effective health care treatment available today. Following your diagnosis, the doctor will advise you of their plan for treatment, Additionally, we will discuss with you the cost of today's and future treatments.

Payment for today's visit and your future visits is due at the time of treatment. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we do offer several alternative payment programs for your convenience,

Please indicate below the form of payment you wish to use to settle your account:

1, Payment by appointment - Cash or Check

a. Bank cards     Master Card     Visa     Discover     American Express     Debit Card

b. For any long-term or extended payments, a health care financing program (Wells Fargo, Care Credit)(with approved credit)

\*Revolving payment plan

\*3, 6, or 12 month interest free

\*Extended payment plan

**Please See Reverse Side**