

DR. THOMAS E. SCHINBECKLER  
General Dentistry

PLEASE PRINT

# Welcome To Our Office

Listed below you will find valuable information about our office and some of our procedures.

1. All patients are expected to keep their scheduled dental appointments. Any cancellation of an appointment must be made 24 hours prior to the appointment time. A combination of 2 failed and/or canceled appointments will result in the inactivation of the patient and/or a broken appointment fee.
2. No eating or drinking is allowed in our reception area.
3. For your safety and for the safety of our staff members, Parents/Guardians are only allowed in the treatment room for initial exams and recalls. Please remain in the reception area until all treatment are complete and your child is released.

*I have read the above information and understand the policies.*

Date \_\_\_\_\_  
Patient \_\_\_\_\_  
Signature \_\_\_\_\_  
Witness \_\_\_\_\_

## Welcome To Our Office

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Bk/Std/Cell \_\_\_\_\_  
SS# \_\_\_\_\_ Referred by: \_\_\_\_\_  
Payment to be made by \_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employee \_\_\_\_\_  
Business Address \_\_\_\_\_ Office Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's SS# \_\_\_\_\_ Spouse's DOB \_\_\_\_\_ Employee \_\_\_\_\_  
Spouse's Business Address \_\_\_\_\_ Office Phone \_\_\_\_\_

**WELCOME TO OUR OFFICE -**  
*We look forward to treating you & your family!*

All patients are expected to keep their scheduled dental appointments. Any cancellation of an appointment must be made 24 hours prior to the appointment time. A combination of 2 failed and/or cancelled appointments will result in the inactivation of the patient and/or a broken appointment fee may be charged.

**PATIENTS WITH DENTAL INSURANCE:** Your co-pay will be collected at the time of visit. We will be glad to assist you in obtaining your total benefits. If your insurance benefits are assigned to this office you are fully responsible for any unpaid balance prior to completion. Any outstanding insurance accounts of 45 days will be considered due in full and charged to the patient.

**PATIENTS WITHOUT DENTAL INSURANCE:** Payment in full is expected at the time of service. A professional courtesy of 5% will be given to accounts exceeding \$300.00 if paid in full at the time of visit. We will accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, check, or cash.

**ALL DENTAL PATIENTS:** All patients are expected to pay for dental services as they are rendered. I acknowledge the above and furthermore agree that, in the event this account or any part of it, remains unpaid for thirty (30) days, I will owe 1.34% service charge per month or 21% per annum thereafter on the unpaid balance. In the case of default or failure to pay the fees herein agreed to, the undersigned further agrees to pay all the expenses incurred in collection procedures including reasonable attorney fees, court costs and any other costs of collection.

I hereby give my consent to Nova Family Dentistry to provide: \_\_\_\_\_ with all necessary routine dental care.  
(PATIENT)

\_\_\_\_\_  
(PARENT OR GUARDIAN) (DATE)  
\_\_\_\_\_  
(WITNESS) (DATE)

INFORMATION RECORD