East Boise Dental
Todd R Broyles DDS

PATIENT INFORMATION

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Male ☐ Female

E-mail Address _____

Employer or Parents Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

SSN# _____ Birthdate _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

PAYMENT IN FULL IS EXPECTED AT EACH APPOINTMENT. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ **CREDIT CARD** ☐ **CARE CREDIT** (6 or 12 month options only)

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Address of Insured if Different From Patient Address _____
Street City State Zip

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No **If Yes, Complete the Following**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Address of Insured if Different From Patient Address _____
Street City State Zip

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

TRUTH IN LENDING DISCLOSURE

Please intial that you have read and understand the following office policies:

Our office is committed to providing quality dental services at a reasonable cost. It is our policy to collect payment for services at the time of the appointment. _____

In the event that an account has not closed in 60 days from the date of service, the individual will receive final notification by letter that the unpaid balance is due. If no response is received indicating a willingness to pay, the patient's account will be referred to a professional credit agency and the patient released from dental care at our facility. _____

As a courtesy for those patients with dental insurance coverage, we will file insurance regularly and in a timely manner. However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered and individual and the insurance company. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions during operating hours. _____

I give permission to East Boise Dental to release my dental records to my insurance company, or others to whom I may request my records be sent. _____

I authorize any dental insurance payments to be released to my denitst. _____

CANCELLATION POLICIES

Cancellations must be at least 24 hours prior to appointment time. A minimum fee of $50 is charged for missed appointments or cancellations without 24 hours prior notice. _____

FINANCIAL RESPONSIBILITY:

- Payment is expected at time of service.
- We expect that the account will be cleared within 60 days. Any remaining unpaid balance may be subject to a FINANCE CHARGE of the periodic rate of 1.50% per month, which is an ANNUAL PERCENTAGE RATE of 18%. We compute the FINANCE CHARGE by applying the periodic rate to the "adjusted balance" of your account. That balance is determined by taking the balance you owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. To avoid a FINANCE CHARGE pay the "new balance" shown on your billing statement before the next billing cycle. _____
- There will be a $50 fee for all returned checks._____

I have read and I understand the above Truth in Lending Disclosure and I agree to the financial policies stated therein.

Patient Signature _____ Date _____

Parent or Guardian _____ Relationship to Patient _____

We accept cash, checks, Care Credit and credit cards.