TAMBRINI FAMILY DENTISTRY
Seth A. Tambrini, D.D.S.

INSURANCE INFORMATION

Name of Insured:

Insured's Birth Date: SS#: Group #: Member ID#:

Insurance Provider: Phone:

Patient's Relationship to the Insured: Self: Spouse: Guardian Other:

Questions Regarding Your Dental History and Visit to Tambrini Family Dentistry:

1. What is the purpose of your dental visit today? ______________________

2. How long has it been since your last dental visit? ______________________

3. Are you happy with your current dental health?______________________

4. What is your long-term goal for your dental care? ______________________

5. Have you ever encountered complications from any dental treatment? ________ If yes, please describe. ________

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6. Have you ever had any orthodontic treatment? ______________________

7. Have you ever been treated for gum disease?______________________

8. Are your teeth sensitive to... ☐ Hot? ☐ Cold? ☐Sweets? ☐ Pressure?

ARRANGEMENTS FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. Unless other arrangements have been made with Dr. Tambrini, payment is due in full on the day of service. Our office will gladly accept credit cards or checks at the time of service;returned checks subject to a $25 returned check fee.

Patients who carry dental insurance understand that all dental services furnished are not always covered by insurance provider's coverage limitations. Additionally, patients are responsible for all delivered treatment even if an insurance company pays less or fails to pay their estimated portion. As a courtesy, Tambrini FamilyDentistry will help prepare the insurance forms and submit to dental insurance providers.

Please keep in mind that dental insurance quotes are ESTIMATES on coverage to be provided. The patient remains responsible for the full amount due on their account until the insurance provider makes payment. If the insurance provider has denied payment on a service, or fails to make a payment within 90 days of the date of service, the patient is responsible for the remaining amount due. Insurance "Co-Pays" are the insured's responsibility and will be due at the time of service rendered.

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Signature of Patient, Parent, or Guardian Date Relationship to Patient

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