Downtown Dental

Trey Kenna, DMD, FAGD

Comprehensive Family, Implant, & Sedation Dentistry

400 E. McBee Ave, Suite 108 • Greenville, SC 29601 • Phone 864.438.2646 • Fax 864.241.2010

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Full Name: _____ Patient's SSN: _____

Date of Birth: _____ SEX: M __ F __ Marital Status: S __ M __ D __ W __

Street Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____Work phone: (_____) _____

Cell/Pager number: (_____) _____ Email Address: _____

Employer:_____Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____Relationship to patient:_____

How did you hear about us?_____

How would you prefer us to send appointment reminders? (circle one)

Phone Call Phone Text Email Post Card

GUARANTOR/PARENT INFORMATION (If applicable)

Responsible Party Name: _____ _____ _____
(Last) (First) (Middle)

Relationship to Patient: _____ Responsible Party Date of Birth: _____

Guarantor's Social Security Number: _____ - _____ - _____

Guarantor's Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Cell/Pager number: (_____) _____

Employer's Name: _____ Work Phone: (_____) _____

Employer's Address: _____

City: _____ State _____ Zip Code: _____

PATIENT's INSURANCE INFORMATION

Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone Number (____) _____ Policy Holder's Social Security Number: _____ - _____ - _____

Name of Policy Holder: _____Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

PLEASE READ AND SIGN BOTH FORMS

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Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone number (____) _____

Name of Policy Holder: _____Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

I hereby authorize my insurance benefits to be paid directly to Downtown Dental. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

IMPORTANT OFFICE POLICIES RELEASE OF MEDICAL INFORMATION

I authorize Downtown Dental to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

We value your time and set aside an allotted amount of time for you upon scheduling an appointment. Please arrive at your scheduled appointment time. If you are running late, please contact our office so we can plan accordingly. When you need to cancel, please let us know as soon as you can.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

PLEASE READ AND SIGN BOTH FORMS