

Referral Information

Whom may we thank for referring you to our practice? Billboard Location Internet Search

Money Mailer Yellow Pages Insurance Company Other _____

Name of person or office referring you to our practice: «RefBy Title» «RefBy FName» «RefBy MI» «RefBy Name» _____

Responsible Party if Different than Patient

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Relationship to patient: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Office Policies

Our office sees children starting at age 6. Parents may not accompany children in the treatment room during procedures. One of our staff members will gladly bring you in to the treatment room to discuss fees prior to starting any treatment. Minors under the age of 13 will be required to have nitrous oxide during all procedures. Minors over the age of 13 and adults may need to have nitrous oxide at Dr. Muir's discretion to complete necessary treatments.

Our office uses digital x-rays; these x-rays are the property of Citrus Park Dental. In the event that you would like these x-rays sent to another office, our transfer of record fees is \$25 per patient. These requests require 72 hours to be processed.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

The patient and any other person responsible for payment has a right to refuse to pay, cancel payment, or be reimbursed for payment for any other service, examination, or treatment that is performed as a result of and within 72 hours of responding to the advertisement for the free, discounted fee, or reduced fee service, examination or treatment.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

I acknowledge that I have read the Provider Notice of Privacy Practices from James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Financial Policies

In an effort to keep fees reasonable and to continue to provide quality care, we have established a payment policy.

Our administrative team will be happy to bill your insurance carrier. However, we do require payment of any uncovered services, deductibles, or co-payments to be taken care of at each appointment.

1. All routine dental treatment must be paid in full prior to treatment being rendered.
2. Cash or credit cards are acceptable forms of payment.
3. We have a financial coordinator who will be happy to help you with your individual needs. For treatment plans you will be given an **ESTIMATE** of what your insurance company will pay and any co-payment will be handled according to the above financial policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. This means that in the event an insurance claim is denied in whole or in part, it is the responsibility of the patient to pay the remaining balance. A 1.5% interest rate will be charged on all unpaid balances on a monthly basis until the balance is paid in full.
4. In the event of a missed appointment without a 24 hour notice, a broken appointment fee will be assessed at \$25 per hour.
5. In the unlikely event that your balance is not paid in full, the patient will be responsible for all fees occurred by using a collection agency or other legal means.

DEPOSIT POLICY: For some procedures, a deposit may be required to reserve the appointment time. In the event of a missed appointment without a 24 hour notice, a **NON-REFUNDABLE** penalty will be assessed at the rate of \$50 for a hygiene visit and \$100 for a visit with Dr. Muir. This fee will be deducted from the appointment deposit and **WILL NOT** be re-applied to that or any other treatment fee. The patient will then be responsible for the full fee at the time of service.

I have read, understand, and agree to the financial policy outline above.

Signature of Patient or Guardian

Date

Citrus Park Dental
7620 Gunn Hwy.
Suite 180
Tampa, FL 33625
(813)926-6776

SMILE ASSESSMENT FORM

1. I am concerned about the appearance of my teeth or my smile.
 Yes No
2. I am concerned about the whiteness of one or more of my teeth.
 Yes No
3. I am concerned about the position or angle of one or more of my teeth.
 Yes No
4. I am concerned about the shape of one or more of my teeth.
 Yes No
5. I have old fillings or previous dental treatment that is no longer satisfactory to me.
 Yes No
6. I am missing one or more of my teeth.
 Yes No
7. I am interested in learning more about aesthetic dentistry.
 Yes No
8. Do you feel you show too much gum tissue?
 Yes No
9. In social situations, I am sometimes embarrassed by my teeth or smile.
 Yes No
10. On a scale of 1-10 (10 being the best) how would you rate your smile?
