Exceptional Cosmetic and General Dentistry for the entire family.

Welcome! Thank you for choosing our dental office for your dental needs. We look forward to providing you quality care in a relaxing atmosphere!

PATIENT INFORMATION

Patient Name________________________________Preferred Name________________Date of Birth____________
Address____ City______________ State______ Zip______________
Male_________ Female__________ Social Security Number____
Phone #'s Home:_______________________Cell:_______________________Work:________________________
Preferred Daytime Phone______________________ E-mail address _______________________________________
Employer____ Occupation____________________________________
Preferred Appointment Confirmation Method: ____ Text ____ E-mail ____ Phone at this #_____________
If patient is a minor, legal guardian?____
Who may we thank for referring you to our office?____

FINANCIALLY RESPONSIBLE INFORMATION

Name____ Marital Status_______________________
Complete Address____
Home Phone:___________________ Cell Phone:____________________ Daytime Phone:_____________________
Date of birth_______________________________ Social Security Number___________________________________
Employer____ Occupation____________________________________
Work Phone________________________________ Relation to patient______________________________________
E-mail address____ D.L. No.______________________________

Spouse/Significant other____
Date of birth_______________________________ Social Security Number___________________________________
Employer____ Occupation____________________________________
Work Phone________________________________ Relation to patient______________________________________
E-mail address____ D.L. No._____________________________

EMERGENCY / ALTERNATE CONTACT INFORMATION

Name of nearest relative not living with you____
Address____ Home Phone_________________________

I acknowledge that I have read and received a copy of the "Office Privacy Policies and Procedures" for the dental office of James D. Lund, DDS. I also acknowledge that my questions have been answered to my satisfaction. I understand that if I have questions or concerns I may contact the HIPAA Officer: Dr. James D. Lund at (801) 254-7777.

Name (please print)____ Date______________________
Signature____
Witness by Office Personnel____

James D. Lund, D.D.S.

Financial Information

● Payment is due at time of service. As a condition of treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are rendered. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred.
● Estimated fees are extended for a period of three (3) months from the date of the patient examination.
● As a courtesy to all guests we extend the use of our outside payment service, which offers a wide variety of interest-deferred payment options as well as long-term payment plans.
● Due to the complexity of insurance contents, estimated amount(s) is/are not a guarantee of insurance, or patient payment. Insurance benefits may be subject to, but not limited to, eligibility, plan maximums and limitations, and insurance fee schedules. Any account balance over sixty (60) days will be subject to a 21% annual (1.75% monthly) service charge and late fees. I understand that it is my responsibility to provide my correct-updated insurance information and that this office will bill my insurance as a courtesy to me.
● There is a $20.00 service charge for checks that are returned unpaid.
● Patient, or financially responsible person(s), agrees to be responsible for all amounts owing. In the event any amount(s) is/are referred to a third party debt collection agency, I agree in addition to any other amount(s) allowed by law, (such as interest, late fees, reasonable attorney fees, court costs, etc.) that a collection fee of up to 40% of the principal amount(s) owing may also be charged to any principal balance as allowed by Utah Code Annotated, sec. 12-1-11. These terms shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
● This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality care, are null and void.

RESERVATION / APPOINTMENT INFORMATION

● I grant my permission to James D. Lund, DDS or his assignee to telephone me at home or at my workplace to discuss matters related to this form or concerning appointments. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.
● I authorize James D. Lund, DDS, or his assignees to release financial information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.
● We make every possible effort to get each guest in to see a doctor and/or his associates/assistants/hygienists in a timely manner. To assist us in staying on schedule we appreciate respect for prompt arrival of your reservation time.

- I understand there is a $68 fee for missed or canceled appointments with less than 24-hour notice.

Thank you for reviewing this important information and respecting our business procedures. Our dental team is available Tuesday through Friday to answer any questions you may have about your account, scheduling a reservation, or just to chat. We will do everything in our power to make your visits with us exceptional!

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outlined above. I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

I acknowledge that a copy of the “Office Privacy Policies” for James D. Lund, DDS, PLLC has been given to me.

____ ____________________
Name of guest, parent/legal guardian (please print) Date

____ ____________________
Signature of guest, parent/legal guardian Office Personnel Witness

IMPORTANT DENTAL INSURANCE INFORMATION

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, limitations, deductibles and required co-payments and/or co-insurance.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance claim within 24 hours of your visit and requesting payment of your benefits to this office.
2. Assisting you in researching your dental insurance plan to determine available benefits.
3. Re-filing your insurance a second time within 45-60 days.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATION OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered by your insurance plan is due at the time services are delivered/rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 65 days.
5. Keeping our office informed of any changes in your insurance coverage, home address, or employment.
6. Understanding that amounts and fees regarding treatment and insurance are an estimate and are subject to change.

Patient Name:____ DOB:____________________________

Insurance Company:______________________________________ Phone: ___________________________

Insurance complete address: ____

Subscriber Name: ____________________________________ Employer: ___________________________

Subscriber D.O.B.: _____________ Subscriber SSN: ______________________ Ins. ID No._____________

Thank you for your cooperation with your dental insurance coverage. Please sign below and have your insurance card ready for us to make a copy to keep in your file.

I hereby authorize James D. Lund, DDS and/or all associates to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to James D. Lund, DDS.
I understand I am responsible for any unpaid balance, regardless of estimated quotes.

____ ___________________________

Signature of insured/subscriber, or legal guardian Date

James D. Lund, DDS • 10430 South 2700 West • South Jordan, Utah 84095 • (801) 254-7777