Tilger Center for Dentistry, P.A.

www.tilgercenterfordentistry.com

938 Gemini • Houston, TX 77058

tilgerdental@gmail.com
(281)480-6900

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Spouse or Responsible Party Information

Employment Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Secondary Insurance Information.

As a courtesy, we will file your secondary insurance, but will not accept assignment of benefits.

Secondary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party): *

_____

_____

Relationship to Patient:

_____

_____

Date: *

_____

_____

Response Date: ___/___/_____

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Office Policies

Thank you for choosing Larry W. Tilger, D.D.S. P.A. We realize that you have a choice in selecting your dental care provider and are honored that you have chosen us. Our goal is to present you with the best solution possible to treat your personal situation, and our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with some information regarding our office policies. Please feel free to speak to our business staff if you have any questions.

INSURANCE- Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include co-insurance. We estimate your portion based on the most up-to-date information we received from your insurance company, but it is ONLY AN ESTIMATE. We will work with you to assure that you receive the maximum benefits to which you are entitled.

We are happy to file your insurance claims as a courtesy. You are responsible to pay, at the time of service, any co-pays, deductibles, co-insurances, and any non-covered services. If we are unable to verify your insurance coverage before your appointment, you may either reschedule your appointment or be held responsible for all fees accrued on that particular date of service. If insurance does not pay within 90 days, the service charges will be your responsibility.

CHANGE OF INSURANCE- Please remember that it is your responsibility to inform our office, of any changes in your insurance coverage in advance. Failure to do so could result in services that are rendered to you becoming your financial responsibility.

PAYMENT- Please remember that payment is due at the time of service. For your convenience, we accept cash, Debit Cards, Visa, Mastercard, Discover, American Express, and CareCredit.

APPOINTMENT- Our office reserves a specific amount of time exclusively for you. To ensure that all our patients get adequate and efficient service, we reserve your next hygiene appointment after each routine check-up and ask that you request your planned treatment appointment in advance. If you are more than 15 minutes late for your appointment it will be necessary to reschedule you to another day and time.

Our office uses Emails and Text Messages to remind you of your appointments. Emails are used to remind you of your appointment scheduled 1 or more weeks in advance. Text messages are sent out to help remind you of your confirmed appointment 7 days, 2 days before and the same day as your appointment. Once you confirm you will receive a thank you text. Since emails and text messages are automatically generated, if your plans change for any reason, it is your responsibility to call our office directly at least 48 hours prior to appointment with the hygienist and 72 hours with the doctor. A $50 per hour schedule fee for the hygienist and a $250 per hour fee for the doctor will be assessed to your account. We will be happy to assist you and to accommodate your needs. *

☐ Initial here that you have read and understand this paragraph regarding Appointments

DEPOSITS - Deposits are taken to reserve the time allowed for your expected dental procedure. Deposits are 1/3 of the estimated patient portion. Deposits are required for any procedure that will take an hour or longer and it will be applied to your total payment for the treatment. Deposits are non-refundable. *

☐ Initial here that you have read and understand this paragraph regarding Deposits

Again, thank you for choosing Larry W. Tilger, D.D.S., P.A.

Signature _____ Date _____

Response Date: ___/___/_____