



WELCOME

Tyler Borg, DDS, MS

Katelyn Fleming, DMD, MSD

Matthew Johanson, DMD, MS

Mark Wheeler, DMD

Anthony Rademacher, DMD, MSD

Thank you for joining our periodontal practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest periodontal care. Please fill out the following pages and ask if you have any questions.

PATIENT INFORMATION			TODAY'S
DATE _____			
LAST NAME	FIRST	M.I.	NICKNAME
STREET NUMBER & NAME		CITY & STATE	ZIP CODE
HOME PHONE NUMBER	BUSINESS PHONE NUMBER	CELL PHONE NUMBER	
EMAIL ADDRESS	SOCIAL SECURITY NUMBER	DATE OF BIRTH - AGE	
FEMALE or MALE			
BUSINESS NAME	OCCUPATION	SEX	
REFERRED BY WHOM: (name of dentist, or friend)			
EMERGENCY CONTACT			
NAME	TELEPHONE	RELATIONSHIP	

Statement of Financial Policy

Please initial and sign, indicating your understanding of the following information. If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of Colorado Gum Care.

_____ It is your responsibility to provide the office with current and correct insurance information. Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

_____ We do not always know if you have a deductible, if your deductible has been met, or if you have co-insurance. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

_____ If you have a co-pay or and/or estimated patient portion, you are expected to pay this when you check in for your visits. Most insurance companies assign a patient portion to recall appointments and operative visits. It is our responsibility to collect this at the time of service. We accept cash, checks, money orders, Visa, Master Card, Discover and American Express. Be prepared to pay when you check in for each visit.

_____ You will be charged a \$75.00-\$150.00 fee if you fail to show up for your appointment or if you cancel your appointment without proper notice.

_____ We do offer financial arrangements with a 10% processing fee added up front. We also accept Care Credit and Lending Club.

_____ A pre-determination of benefits will only be sent to the insurance at your request.

_____ A non-refundable deposit will be required when scheduling IV sedation cases and any surgical appointments at the doctors request.

_____ Patients are responsible for the treatment cost not covered by insurance, along with any incurred collection and/or attorney fees. In the event that your account is assigned to a collection agency, you agree to pay a collection fee in the amount of 50% the charged off balance due.

_____ I hereby authorize this Colorado Gum Care and its employees, agents, and assignees to contact me via e-mail and text messaging, and to my cellular devices.

_____ I consent to Credit Control Agency and its assignees to communicate with me by telephone, e-mail, fax, or other means.

Patient or Guardian

Date

Cancellation Policy

Colorado Gum Care strives to deliver excellent dental care to all of our patients. In order to be consistent with this philosophy, we have implemented the following appointment cancellation policy:

Surgical Visits

We request that you give our office a seven day notice in the event that you need to reschedule or cancel your procedure with the dentist. This includes all treatment visits with the dentist. If you miss an appointment for the surgical visit without providing us with the proper notice, we will consider this to be a missed appointment and a \$150.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

Office visits and Cleanings

We request that you give our office at least two full business days' notice in the event that you need to reschedule or cancel your appointment with the dentist or hygienist. If you miss an appointment for the office visit without providing us with the proper notice, we will consider this to be a missed appointment and a \$75.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

As a courtesy, we do make reminder calls, texts and/or e-mails 10 days prior to your appointment. We will also contact you to confirm your appointment 3 days prior. If you do not receive your messages or we have incorrect information, the cancellation policy will still be in effect.

Patient or Guardian

Date



Pharmacy information Sheet

Patient Name: _____ Date: _____

Pharmacy Name _____

Pharmacy Phone: _____

Pharmacy Address _____

City _____ Zip _____