THANKSGIVING POINT DENTAL
Blair I. Losee D.M.D.
3098 North Executive Parkway Suite 250
Lehi, UT 84043
766-5300

Patient Information Form

Please make sure to read, sign and date the back of this form.

Step 1 Please start here. If a box does not apply, please enter n/a.

Patient Full Name (First, Middle, Last)

Street Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Date of Birth | Social Security Number

Single ☐ Married ☐ Divorced ☐ Widowed ☐ | Email Address

Employer | Work Phone Number

Work Address

If filling out paperwork for your child:

Parent/Legal Guardian Name

Address, if different from your child

City | State | Zip Code

Step 2 Insurance Information

Subscriber's Full Name

Group/Employer's Name

Dental Insurance Company

Subscriber's ID # | Subscriber's SSN

Dental Insurance Address

Group Number | Effective Date

City | State | Zip Code

Customer Service Phone Number | Date of Birth

Step 3 Referral Source and Emergency Contact Information

How were you referred to us?

Emergency Contact Name

Is a member of your family a patient in our office? If so, please list their name.

Emergency Contact Address

Would you like to be reminded of your appts by: ☐ Email ☐ Text Message ☐ Phone Only

Home Phone | Work Phone | Cell Phone

Step 4 Office Policies

We are Preferred Providers with Aetna, Cigna, DMBA and Dental Select-Platinum and we work with and bill most insurances. As a courtesy to you we are happy to bill your insurance and contact them to review your insurance benefits. Ultimately the patient is responsible for knowing their dental benefits.

Because we are not preferred providers for Blue Cross Blue Shield and Delta Dental, payment for services rendered will be sent to the patient. A 10% discount is available to patients when they pay in full at the time of service by cash/check. The patient would then be reimbursed by their insurance company.

Please give us at least 24 hours for appointment changes. A $68 late cancellation fee may be billed to patients for repeat no-show and late appointment changes. Please call during regular business hours to re-schedule appointments as our voicemail does not accept appointment changes.

Step 5 Please Read Our Federal Truth-in-Lending Statement and Sign and Date Below.

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who have dental insurance understand that all dental services furnished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month, 18% annually, on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for 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, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term 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 is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home, on my cell phone and at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Blair I. Losee.

I certify that I have answered all questions on the form accurately. I hereby agree to abide by the conditions outlined there in.

Signature of Patient/Legal Guardian Date