David Willoughby DDS

6111 Taylor Ranch Drive NW
Albuquerque, New Mexico 87120

NEW PATIENT INFORMATION – Payment Agreement

Oral health is an important part of overall health.
Thank you for the confidence you are placing in our team of health care professionals.

Welcome to our practice! How did you find out about our office?

❑ Internet Search ❑ Delta Dental Provider List ❑ Yellow Pages ❑ Referred by friend or family
❑ Saw office or I live in the neighborhood ❑Other _____

If you were referred to our office by someone else, whom may we thank? _____

PATIENT PAYMENTS

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Patient payments may be made by cash or credit card (Mastercard, Visa or American Express). Personal checks are gladly accepted from established patients.

Dr. Willoughby also offers patients the option to apply for credit through CareCredit. Patients who qualify can make convenient payments over time and with CareCredit – unlike other credit cards or traditional loans – *there is no requirement for any additional interest payment when payments are made according to the agreed upon repayment schedule.*

DENTAL PLAN BENEFITS OR INSURANCE, WHEN APPLICABLE

As a courtesy to our patients, we file claims for dental plan benefits and collect only the estimated patient portion at the time services are received. Dental plan benefits are, however, an agreement between you and your employer or dental insurance company. If dental plan benefits are not paid within 60 days from the date of treatment, the patient or responsible party will be billed directly for any unpaid treatment plan costs. **David Willoughby DDS is not able to guarantee benefits and patients are always responsible for payment if full of all charges.**

With your signature on this form, you authorize David Willoughby DDS to release to your dental insurance company or benefits administrator any information necessary for the payment of benefits, assign any benefits for treatment received (for yourself or any covered dependents) to David Willoughby DDS, and authorize payment of those benefits directly to David Willoughby DDS.

If you are covered under a dental plan, your signature below also confirms your agreement to pay amounts due for treatment received, up to the full treatment cost, for any amounts not paid as dental plan benefits within 60 days from the date of treatment.

With my signature below, I acknowledge my understanding of the patient payment information provided above and, except as noted in the insurance section above, agree to pay amounts due *at the time of service***.** I have received, if requested, a copy of this form.

Patient or Responsible Party (please print) _____

➡ Signature _____ Today's Date _____

Visit SmilesThatWork.com to read our most recent newsletter, learn more about our office (including updates about our monthly Patient Referral Appreciation gifts), or request an appointment time.

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NEW PATIENT INFORMATION - Please print

Patient Name_____ Date of Birth _____Age_____

Home phone _____ Work _____Cell _____Email_____

Patient SSN _____ Drivers License No. _____

Patient's Marital Status M S D W / Emergency Contact Name: _____

Relationship_____ Phone_____

Patient's Home Address _____ City_____

State _____ Zip_____

Patient's Employer:_____ Work Phone _____

Patient's Occupation _____

Parent or other Responsible Party name, if applicable _____

Relationship to patient _____ Date of Birth_____

Responsible Party Address_____ City_____

State_____ Zip_____

Responsible Party SSN_____ Drivers License No. _____

Responsible Party email _____ Phone _____Cell_____

Primary Insurance	Secondary Insurance, if applicable
Insurance Company_____	Insurance Company _____
Employer Name, if group plan: _____	Employer Name, if group plan: _____
Group or Policy No. _____	Group or Policy No._____
Insurance Company Address: _____ _____	Insurance Company Address: _____ _____
Ins. Company Phone: _____	Ins. Company Phone_____
Name of Insured (Subscriber), if different from patient (example, a spouse covered by the other spouse's plan): _____	Name of Insured (Subscriber), if different from patient (example, a spouse covered by the other spouse's plan): _____
Insured/Subscriber SSN:_____	Insured/Subscriber SSN _____
Insured/Subscriber Employer:_____	Insured/Subscriber Employer_____

With my signature below, I confirm the accuracy of the information provided above.

Patient or Responsible Party (please print)_____

Signature_____ Today's Date_____

Please also read and complete, and sign the other side of this form.