Henson Family Dentistry

6230 Highland Place Way, Suite 202
Knoxville, TN 37919
865-588-0578

PATIENT INFORMATION

First Name _____Middle _____Last_____
Preferred Name _____
Address _____City _____State ____Zip _____
Cell #_____ Other Phone #_____E-Mail _____
Birth Date _____SS #_____
Employer _____
Spouse _____ Employer _____ Cell #_____

Previous Dentist: _____ Approximate Last Visit _____
Please send any current x-rays to: office@hensonfamilydentistry.com
Who may we thank for referring you: _____

Insurance Policy Holder / Responsible Party Information (If different from above)
***Dental Insurance Card Required at Visit**

Responsible Party Name_____Cell #_____
Address _____ City_____State ___ Zip_____
Employer _____ SS# _____ Birth Date _____
Patient Relation to Responsible Party: Spouse _____ Child _____ Other _____
Dental Ins._____ ID#_____ Group #_____

Office Policies

Insurance: In order for us to file your insurance, we require you to have your dental insurance card present. It is important for you to understand your dental insurance coverage and requirements, including your deductible and required co-payments. Please remember your insurance is a contract between you and the insurance carrier. You alone are responsible for your account.If we do not receive a response from your insurance company within **30 days** of filing your claim, you are responsible for payment of your account in full.

Payment: Payment is expected at the time of your treatment. We accept cash, checks, MasterCard and Visa and American Express. A finance charge of 3.5% per month may be applied to accounts 60 days past due. Written treatment options with associated costs will be explained to you upon request. We offer payment plans through Care Credit. The parent or legal that requests treatment for a minor will be responsible for payment in full. I acknowledge responsibility for all charges incurred. I understand and acknowledge that if my dental account becomes delinquent, I will be responsible for payment of all collection fees, court costs, and attorney fees.

Appointments: In order to provide timely dental care, this office reserves this time especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance. **No-shows** or **last minute cancellation** may result in a **$50 cancellation fee.** All appointments over one hour may require prepay.

Assignment of Benefits: I authorize the release of any information necessary for processing of insurance claims and referring dentists.

I have read and agree to above Policies. I have read or received a Notice of Privacy Practices

Patient Signature:_____ Date:_____