H.J.Turner III, D.D.S., M.S.

Pediatric Dentistry
of
Spartanburg & Gaffney

D. Jensen Turner, D.M.D.

Patient Information			
Last Name		First Name	
Middle Initial		Preferred Name	
Street Address		Birth Date	
City		Sex (M/F)	
State		Zip	
Social Security #			
Cell Phone		Secondary Phone	
Email			

Guarantor Information (Person Responsible for Bill)			
Last Name		Social Sec. #	
First Name		Birth Date	
Middle Initial		Sex (M/F)	
DL #			
Street Address			
Cell Phone		Secondary Phone	
City		State	Zip Code
Email			
Guarantor Employment Information			
Employer Name		Employer Phone	
Street Address		Suite/Apt#	
City		State	
Zip Code		County	

Insurance Information for Patient - Provide Complete or provide copy of insurance card		
Insurance Company #1	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:
Insurance Company #2	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:

Signature of Patient/Guardian: _____

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Office Policies

Acknowledgement of Receipt of Notice of Privacy Practices
Your signature below acknowledges that you understand that your medical information will not be released to any individual unless indicated of the bottom of this form. This is in compliance with The Health Insurance Portability and Accountability Act (HIPPA) of 1996.

We welcome you to our practice and look forward to the privilege of meeting your healthcare needs. Please don't hesitate to let us know at any time if we are not meeting your needs, or if you have questions. Below is some information about certain policies of our practice that you need to understand.

Dental Insurance and Financial Policies:
As a courtesy to our patients, we will file your insurance based on the information you provide. Most plans only cover a portion of the dental fee, which means you, will be responsible for your deductible and the portion we estimate your plan will not cover. We will provide you with an estimate, but due to insurance terms, eligibility, and clauses, the estimate is not exact. For more specific details concerning your insurance, you should contact your insurance company. Payment of your estimated portion is expected at the time you are in our office for dental care. Please note that any deductibles or co-payments are strictly an estimate and there may be a balance remaining after your insurance pays. Some, or perhaps all, of the services provided may be non-covered services and not considered for payment by your dental plan. We do not base our treatment recommendations on the benefits of any insurance policy, but solely upon the dental health needs of our patients.

We are committed to providing you with the best care possible, and we are pleased to discuss our Professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

Payment Options:
We accept cash, checks, and most credit cards. We also offer interest free financing for qualifying patients, through Care Credit . Please see our financial coordinator for more information.

Missed Appointments:
We value you as a patient and we specifically set a special time for child's needs. Before your scheduled appointment, you will receive several reminders about your appointment. Please confirm your child's dental appointment or reschedule 48 hours prior to your child's appointment. If your child's appointment is broken less than 24 hours' notice, we reserve the right to refer you to another dentist office. Also, if your arrival is more than 15 minutes beyond your reserved time, we may have to reschedule your appointment.

By signing below, I state that I have read and understand the policies of Pediatric Dentistry of Spartanburg. I also give consent for my child to receive a cleaning, fluoride treatment, examination, and x-rays as deemed appropriate.

I, authorize the persons listed below to bring/pick-up_____ to any dental appointments & can make any decisions concerning his/her dental treatment.

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

Parent/Guardian Signature _____ Date _____