

**Welcome to Our Practice** This confidential information will help us prepare for your visit.

**NAME** \_\_\_\_\_  
Mr. Mrs. Ms Rev. Dr.

I prefer to be addressed as \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

Address \_\_\_\_\_ PO Box \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

E-mail address \_\_\_\_\_

Cell # \_\_\_\_\_

**Employer** \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ There for \_\_\_ yrs

Where and when is best to reach you? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Other family members seen by us \_\_\_\_\_

Last dental visit \_\_\_\_\_

Seen by Dr. \_\_\_\_\_ for \_\_\_\_\_

Why have you made this dental appointment at this time?

Why did you leave the office of your previous dentist?

**Dental Insurance Information**

**PRIMARY**

Insured Name \_\_\_\_\_

Insured Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

**SECONDARY**

Insured Name \_\_\_\_\_

Insured Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

As a courtesy to our valued patients, we will file claims for your insurance on your behalf. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our normal fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. James F. Otten, D.D.S. does not participate with any insurance companies in the fee schedules they have developed. In deciding whom he should participate with the doctor has selected YOU. We respect the trust you place in us and believe that our relationship is negatively affected when third party interests are mandated. We will do our very best to see that you receive all of the benefits due you.

**PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK**

**Spouse's Name** \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Work # \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ There for \_\_\_ yrs

**Account Information**

**Name on Account** \_\_\_\_\_

Self  Spouse  Other

I may wish to establish a credit history with your office for personalized financial agreements. I authorize a credit history report.

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I understand that dentistry is an inexact science and authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written and signed financial agreements have been made. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

*Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.*

**James F. Otten, D.D.S.**  
**930 Iowa, Suite One**  
**Lawrence, KS 66044**

**785-843-6404**

# James Otten Dentistry

BRILLIANT SMILES

*exceptional care for people who care*

## James Otten Dentistry Financial Policy

At James Otten Dentistry, we are dedicated to keeping you informed about not only your dental options, but also your financial options. Like our care, our fees are individualized to your specific needs and oral health goals and you can always be assured that you are charged a fair fee for the excellent care provided to you. Because we do not want financial misunderstandings to compromise our relationship with you, we've created a clear and concise financial policy so that you will know exactly what to expect.

Payment is due at the time of service, and we accept the following options:

- Cash
- Check
- American Express
- Mastercard
- Visa
- Discover
- FSA (Flexible Spending Accounts)
- HSA (Health Savings Accounts)

### FINANCING

We are proud to say that we also offer low or no interest financing options through Care Credit.

### INSURANCE

We will do everything we can to help you get the maximum possible benefits under your dental insurance policy, and that includes filing your claim directly with your insurer. Since your policy is a contract between you and your insurer, your benefits will be paid directly to you. You are responsible for making the full payment for your dental services.

Regardless of the payment option you choose, we will never compromise on the quality of care that we provide. Our goal is to provide you with all of your dental care options, as well as the risks and costs associated with them. From there, it is up to you to decide what level of care you want to pursue.