

Arthur W. Thurm, DMD, PA  
925 Haddon Avenue  
Collingswood, NJ 08108

For office use:  
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**Patient Information Form**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

home phone \_\_\_\_\_ work phone \_\_\_\_\_ cell phone \_\_\_\_\_

cell phone will only be used if we cannot contact you by other means

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's name \_\_\_\_\_

Your Social Security # \_\_\_\_\_ Your date of birth \_\_\_\_\_

Your E mail address: print clearly: \_\_\_\_\_

To be used to contact you about appointments and office information

Referred to our office by: \_\_\_\_\_

Are you interested in being asleep (under general anesthesia or sedation) for all or part of your dental services? \_\_\_yes\_\_\_no

Who should we contact in the case of an emergency?

\_\_\_\_\_ phone \_\_\_\_\_

Name of nearest relative not living with you:

\_\_\_\_\_ phone \_\_\_\_\_

Do we treat any other members of your family? \_\_\_\_\_

Who is financially responsible for this bill? \_\_\_\_\_

Are you covered by dental insurance \_\_\_yes\_\_\_no

If so, name of insurance \_\_\_\_\_ Group # \_\_\_\_\_

Insured's name \_\_\_\_\_ Insured's date of birth \_\_\_\_\_

Insured's social security # \_\_\_\_\_ Insured's employer \_\_\_\_\_

I will be paying today by cash \_\_\_\_\_ check \_\_\_\_\_ credit card \_\_\_\_\_

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read the information on the back of this sheet. and have completed the above answers. I certify that this information is true. and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's signature or parent \_\_\_\_\_ Date \_\_\_\_\_

## About Financial Arrangements and Dental Insurance

Please initial that you have read and understand the following: initials \_\_\_\_\_

**We are committed to providing you with the best possible care.** If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, and all major credit cards. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances we may accept assignment of insurance benefits. Credit reports may be requested from a national credit reporting service for patients who assign insurance benefits or request extended payment plans.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5 % per month. If an attorney is retained to collect past due amounts on your account, you will be responsible for these additional fees. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore covered up to the maximum determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is defined as usual, customary, and reasonable for this region. Thus, our fees are considered UCR by most companies. Some companies set their own arbitrary fees which are much lower than UCR. This will result in a greater cost for the patient, and a lesser cost for the insurance company.
3. Not all services are a covered benefit in all contracts.

**We must emphasize that as dental care providers, our relationship is with you, not your insurance company. We will recommend the best possible treatment for you, regardless of your insurance coverage. As the patient you should be aware of the limitations of your dental plan, but you should not let those limitations affect the quality of dental care you choose to receive.**

If you would like a copy of our financial policy, please ask one of our staff and we will be happy to provide you with a copy for your records.

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Arthur W. Thurm, DMD, PA  
*A Family Dentistry Association*  
925 Haddon Avenue  
Collingswood, N.J. 08108-1902  
856 858-2871 Fax 856 858-7169

**Authorization for Submission of Claims  
And Assignment of Benefits**

I authorize the health care provider above to submit claims for payment for services to the health care plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Company 1. \_\_\_\_\_

Company 2. \_\_\_\_\_

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

**Authorization For Release of Health Information**

I authorize the health care provider named above to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain in effect for up to five years from this date.  
I know that I have the right to receive a copy of this authorization if requested.

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient, parent or guardian