Ned S. Jennings, DMD, Inc.

1415 Blanding Street | Suite 1 • Columbia, SC 29201 (803)254-9045

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **SS#:** ___-__-____ **Prev. Visit:** ________

Email Address: ____________ **Best time to call:** ________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Prefered number to confirm appointments:
☐ Home ☐ Work ☐ Cell

Whom may we thank for referring you to our practice?
☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Family/Friend:

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____________ **Phone:** ________

Employer Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Email Address:** ____________

Phone: ________ ________ ________ ____ **Best time to call:** ________
Home Mobile Work Ext

Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ______________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Consent for Services

We are commited to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits. TO achieve these goals, we need your assistance and understanding of your financial arrangement with our office.

Payment for services is due at the time services are rendered unless arrangements are made in advance. If you have insurance, we will submit your claim for you. You are responsible, at the time of your appointment, for any deductible and/or co-pay not covered by your insurance company. We will estimate your portion so that you will be prepared to pay when services are rendered. This will be an estimate based on the information your insurance company has given us. Once our office has received payment from your insurance company, you will be billed for any amount still due, as you are responsible for any charges that exceed your benefits. If there is a credit, a check will be issued to you, or applied to your next visit. If there is no insurance available, you will be responsible for the full bill at the time of your appointment.

INSURANCE PATIENTS: PLEASE READ CAREFULLY: Please be advised that although your insurance benefits state that you will have 100%, 80%, or 50% coverage, this is based on their fee schedule which my differ from our fees. Lower payment is a result of the plan your employer has chosen for you. We are required by law to collect co-payment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature ______________________________ **Date** ____________

Relationship to Patient:

____

____

Response Date: ____/____/________