goose creek
village dental

Patient Information

First Name: _____ Last Name: _____ MI: ____

Date of Birth: _____ Gender: _____ Soc. Sec. # _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Guardian / Guarantor Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Soc. Sec. # _____ Relationship to Patient: _____

Financial Policy

All payment and copays are due at the time of service. Although we will provide a reasonable estimate of your copay, this amount can change based on insurance restrictions or clauses that may be unknown.

All service completed by Goose Creek Village Dental is your complete financial responsibility.

We do not accept assignment of benefits for secondary insurance. As a courtesy, we will fill out the dental claim for you.

Any accounts greater than 90 days past due will be sent to Collections, and you will be responsible for all fees, penalties, interest, attorney fees and / or court costs associated with Collections activity. You will also be responsible for any negative impact upon your credit score due to Collections activity.

By signing below, I agree to the Financial Policy of Goose Creek Village Dental.

_____

Signature of Patient / Guarantor Date

Appointments Policy

We require 2 business days notice if you must cancel or reschedule an appointment.

There is a $100 no show / late cancellation fee that will be charged to your account for less than 2 business days notice. This fee is not paid by insurance and must be paid in full before we reschedule your appointment.

If you no show / late cancel an appointment, all future appointments for you will be cancelled. This may also apply to other members of your family.

If you no show / late cancel three (3) appointments, you will be advised to seek dental care in another office. A letter will be sent to inform you that you have been dismissed from this practice.

Please be on time for your appointment. Being late may incur a no show / late cancellation fee to be charged to your account.

Violation of this Policy may require full prepayment of dental services in order to be given future appointments.

By signing below, I agree to the Appointments Policy of Goose Creek Village Dental.

_____

Signature of Patient / Guarantor Date

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Patient Name: _____ **Date of Birth:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Notice of Privacy Practices.

_____
Signature of Patient / Guarantor Date

Consent for Dental Treatment

This is my authorization to Dr. Suhad Kim and Dr. Michael Kim, and their associates, to perform all necessary diagnostic, preventative and restorative procedures. This includes, but is not limited to, diagnostic x-rays, cleanings, periodontal treatment, sealants, fluoride treatment, local anesthesia, dental restorations, bite guards, bleaching, emergency dental care. I also understand that this consent does not extend to oral surgery, root canal therapy or crown / bridge treatment, which would require additional informed consent. **Refusal to signing this consent means that we will be unable to accept you as a patient.**

_____
Signature of Patient / Guarantor Date

Assignment of Benefits

This is my authorization and request to my insurance company to pay directly to Goose Creek Village Dental PLLC insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____
Signature of Patient / Guarantor Date

Referral Information

Whom may we thank for referring you to our practice?

Name of person or office:_____

How did you hear about our office?

☐ Google / internet search ☐ HOA newsletter / magazine. Which HOA?_____

Authorization for Dental Treatment for Your Child in Your Absence

It is required that a parent or legal guardian be present for the dental appointment for patients 18 and under.

It is important that you are present with your child at each visit. We can provide better care, answer questions, discuss treatment and address concerns when we talk to you directly about your child.

If circumstances or emergency occurs and you cannot come to your child's appointment, you may authorize the adult(s) listed below bring your child to their appointment.

This is my authorization for:

_____ or _____
Name of friend / relative Name of friend / relative

to seek dental advice and treatment for my child. This authorization is effective until rescinded or changed by me.

_____
Signature of Patient / Guarantor Date