Route 14 Dentistry
Yoodong Moon D.D.S.
6315 North West Hwy,
Crystal Lake, IL 60014
815-455-3368

PATIENT INFORMATION

Last Name _____ First Name _____ MI ____ Date of Birth ____/____/_____
Preferred Name (if different) _____ Sex: ☐ M ☐ F Family Status: ☐ Married ☐ Single ☐ Minor
Home Phone (_____)_____ Cell Phone (_____)_____ Business Phone (_____)_____
Address _____ City _____ State _____ Zip _____
E-mail _____ Referred by _____
How did you hear about our office? (Circle one):
Another Patient | Website | Facebook | Yelp | Insurance Website | Sign-Drive by | Flyer | Other: _____

SUBSCRIBER/POLICY HOLDER INFORMATION

Name of Policy Holder _____ Date of Birth _____/_____/_____
Relation to Patient □ Self □ Spouse □ Child □ Other _____
Insurance Company _____ Employer _____
Policy Holder's ID # _____ Policy Holder's Social Security # _____-_____-_____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone (_____)_____ Relation to Patient _____
Address _____ City _____ State _____ Zip _____

Thank you for choosing Route 14 Dentistry as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our office policy, which we require that you read, agree to, and sign prior to any treatment.

FINANCIAL POLICY

Payment is due at the time of service. Our office accepts cash, personal checks, credit cards, and pre-determined payment arragement. Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal debt collection assistance, you will be responsible for, and agree to pay to office, all collection and/or legal fees, costs and expenses up to 35% of the debt.

***For patients with dental insurance*:**

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. As a courtesy to you we will help you process all your insurance claims. Please understand that we will provider an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, or credit card at the time we provide the service to you. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

CANCELLATIONS AND MISSED APPOINTMENTS

We require at least 24-hour advance notice of a cancellation. Patients who do not provider at least 24 -hour notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Any broken appointment charged will need to be paid before you will be able to reschedule for another appointment.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our office policy.

AUTHORIZATION

I have read, understand and agree to the above terms and conditions. I hereby authorize my insurance company to pay my dental benefits directly to my dental office. I understand that I am responsible for all costs of dental treatment for my dependents or myself at the time of service. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. I have read and understand the cancellation and missed appointment policy. I agree to pay any fees that are charged should I fail to keep an appointment.

Signature of Patient/Legal Guardian_____ Date _____