Ravi Doctor DDS

Patient Information

Confidential Information For Our Records. Please Print & Please Fill Out *ALL* Requested Information

Patient Information

Name: Last First Middle

Address: Apartment #

City State Zip

Home # ( ) - Cell # ( ) - Work # ( ) -

Email address:

DOB: Month Day Year SSN: - - Driver's License #

Employer Occupation Length of Employment

School (If currently a student) Grade

Name & number of your current pharmacy:

Your Spouse or Parent/Guardian

Name: Last First Middle

Address: Apartment #

City State Zip

Home # ( ) - Cell # ( ) - Work # ( ) -

Email address:

DOB: Month Day Year SSN: - - Driver's License #

Employer Occupation Length of Employment

Whom may we thank for referring you to our office?

Name of person:

This person is a: ☐Friend ☐ Relative ☐Co-Worker ☐Physician ☐Other

Is this person a patient in our office? ☐Yes ☐No ☐Don't know

If none of the above, check one: ☐Location ☐Yellow Pages ☐ Internet

Magazine: ☐Panache ☐FW,TX ☐Society Life ☐Other (Please List):

Who should we contact for an emergency?

Name: Last First Middle

Relationship: City State

Home # ( ) - Cell # ( ) - Work # ( ) -

Dental Insurance *****If we were able to make a copy of your insurance card, fill out only the subscriber information***

Carrier Name Phone Group #

Mailing Address:

Subscriber Name: Last First Middle

Subscriber DOB: Month Day Year SSN: - - Subscriber #

Employer Name Phone

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Cancellation Policy:

Cancellations with less than a 48 hour notice will result in a fee of $200 per hour of scheduled time. This fee will waived if you have a doctor's excuse or a certificate of death in the family.

Insurance Policy:

Please remember that your dental insurance is ultimately your responsibility, but we are happy to assist you. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept assignment of benefit payment from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Outlined estimates are based on limited information obtained from your insurance company and can not be guaranteed. We allow up to 45 days for your insurance company to make a payment. After this time, all inquires (follow up) on payments due become your responsibility and your account balance will be due in full.

Financial Policy:

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options. You can choose to pay by cash, check, or major credit card. We also offer no interest payment plans and extended payment plans through our third party financing partners.
A service charge of 1.5% per month (18% APR) is charged on any unpaid balance over 30 days, unless other arrangements have been made. A late fee of $25 will be charged for payments received after the due date

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I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the administration of local anesthetic may cause an outward reaction or produce side effects which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary, or rarely, permanent numbness, or muscle soreness. I understand that occasionally needles break and may require surgical removal.

I understand that my dental insurance is a contract between me and the insurance carrier, not between the doctor and the insurance carrier, and that I am fully responsible for the total treatment fee. I understand that outlined estimates for my insurance benefit and out-of-pocket expense are not guaranteed due to the limited information obtained from my insurance carrier and that I will be responsible for any amounts not paid by my insurance.

I authorize Ravi Doctor, D.D.S., his representatives, or assigns, to access and obtain any information concerning my credit or credit history from any reporting or disclosing agency, bureau, or entity.

I agree to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred as a result of my failure to pay my account balance, as outlined in the above financial policy.

________________________________ ________________
Patient Signature Date

I authorize Ravi Doctor, D.D.S. to use any before and after photos to illustrate examples of cosmetic dentistry.

________________________________ ________________
Patient Signature Date

Southlake Office: 261 East Southlake Blvd., #100 Southlake, TX 76092 817-328-2400

Arlington Office: 1810-A South Bowen Rd. Arlington, TX 76013 817-274-8667