COVINGTON PIKE DENTAL CLINIC
FRED C. HEROS, D.D.S.

3594 Covington Pike, Memphis, TN 38128
Phone: (901) 377.6800 Fax: (901) 377.5360

Welcome to our office

About You

Today's Date _____

Patient Name

_____
Last First M

What You Prefer to be Called _____
Birthdate _____ Age _____
Social Security # _____
Mailing Address _____

_____
City State Zip

Home Phone # _____
Work Phone # _____
Cell Phone # _____
e-mail Address _____

Referred By _____

Employer _____
How Long? _____
Employer's Address _____

_____
City State Zip

Occupation _____

Status: Single ___ Married ___ Divorced ___ Widowed ___

Account Information

Person responsible for account

Name _____
Relationship _____
Billing Address _____

_____
City State Zip

Social Security # _____
Work Phone # _____
Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

Secondary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

In Event of Emergency

Who should we contact? _____
Relationship: _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____

Are you currently under the care of a physician?

If so, why? _____
Doctor Name: _____
Phone Number: _____

Please continue on back →

Office Policies for Covington Pike Dental Clinic

We are so glad you have chosen us as your family dental practice. We strive to provide you and your family the best dental care possible, but feel that proper communication between our patients and staff is of utmost importance. The following guide is a summary of our guidelines and office policies. We ask that you review these guidelines and refer to them any time you have a question or problem.

Appointment Policies:

- A parent or legal guardian MUST accompany a child under age 18.
- If you are unable to keep an appointment, please notify our office at least 24 hours in advance. Failure to do so could result in suspension from our dental practice. We understand emergencies warrant short term cancellations, but broken appointments can be costly and unfair to other patients, so we ask that you notify us as soon as possible if you are unable to keep an appointment.
- Failure to arrive to your appointment on time can cause delays for those who arrive promptly. Please call our office as soon as possible if you know you will be late. We will make every attempt to work you in, but it may be necessary for you to reschedule your appointment if you are more than 10 minutes late or do not show up for your appointment. This will be counted as a broken appointment. **Once you have broken 2 appointments, we will no longer be able to see you as a patient in our office.**

Treatment Room Policies:

- It is our policy that parents remain in the waiting room while we are treating your child. We understand this may be a nervous time for you and your child, but we would appreciate your cooperation in this matter.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse