Dr. Hughes

Date_____

Name_____DOB_____SSN_____

Address_____City_____State_____Zip_____

Phone# _____ Cell #_____email address_____

Patient or Parent Employer_____Work Phone_____

Spouse Name_____Employer_____

Emergency Contact_____Phone_____

1st Insurance Subscriber_____DOB_____SSN_____

Name of Employer_____Insurance Co. _____

2nd Insurance Subscriber_____DOB_____SSN_____

Name of Employer_____Insurance Co._____

How did you hear about us_____

Payment Policy

Payment is **due at time of service**. We accept cash, check, credit card, and care credit. **We do not offer payment plans**.

Insurance claims: It is the patient's responsibility to know your insurance contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims. You are responsible for any unpaid insurance claims.

Cancellation Policy

At Hughes Dental we value you as a patient and respect your schedules. We also understand emergencies arise. When we have a last-minute cancellation, it eliminates our ability to see another patient in need. We strive to provide the best care to our patients, any canceled appointments without 24 hours' notice will be charged a cancellation fee of $25.00.

I have read and agreed to the policies of Dr. Hughes.

Signature _____Date_____