Joseph N. Grimaudo, DMD
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All Smiles Tampa Bay
Family & Cosmetic Dentistry

17200 Camelot Court
Land O' Lakes, FL 34638
(813) 345-8580

Patient Information

Patient Name: _____ Nickname/Preferred Name: _____

Date of Birth: _____ Gender: ☐Male ☐Female Family Status: ☐Single ☐Married ☐Child ☐Other

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

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

May we text and email you appointment reminders and information related to your dental treatment? ☐Yes ☐No

Whom may we thank for referring you to our practice?

☐ Friend/Family ☐ Internet/Website ☐ Health Fair/Expo ☐ Insurance Directory ☐ Newspaper/Advertisement ☐ Other (see below)

Name of person, place or event referring you to our practice: _____

Financial Information

Person responsible for payment: _____ Relationship to patient: _____

Employer Name: _____ Employer Phone: (_____)_____

Primary Dental Insurance Name of Insured: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

Insurance Address: _____

Group Number: _____ ID Number (SS#): _____

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most ***comprehensive dental care*** *using the* ***highest quality materials and technology*** *available in the profession today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.*

All charges you incur are your responsibility regardless of your ***insurance coverage****. 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 an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement.*

In consideration for the professional services rendered by this practice, payment is due in full at time of treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

As a courtesy to our patients, this office will help prepare dental insurance forms and assist in making collections from a primary insurance company. Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. If payment is not received from your insurance company in 60 days from date of service, you will be expected to pay the balance in full.

Our practice accepts cash, personal checks, MasterCard, Visa and Discover. Returned checks and balances older than 60 days will be subject to finance charges at the rate of 1.5% per month (18% annually) on the unpaid balance and may result in collections.

Our practice requires 48 hours notice to cancel an appointment. You will be charged a cancellation fee if you do not keep an appointment, or cancel within 48 hours of scheduled appointment time.

I have read the above conditions of treatment and payment and agree to their content. I authorize all insurance payments to be made directly to All Smiles Tampa Bay.

Signature of responsible party: _____ Date: _____