

Joseph A Wescott DDS

Island Dental

We are pleased to welcome you to our practice. Please take a few minutes to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

Prefer to be called: _____

Male Female Married Single Other

Birthdate: _____

SSN: _____

Home address: _____

City: _____

State: _____ Zip: _____

Hm: _____

Wk: _____

Cell: _____

Email: _____

Employer: _____

Whom may we thank for referring you?

Previous Dentist: _____

Last Visit Date: _____

Phone: _____

In the event of an emergency, is there someone who lives near that we should contact?

Name: _____

Relation: _____

Phone: _____

Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's DOB: _____

Insured's SSN: _____

A note for our patients with dental insurance:

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however, regardless of what your insurance plan pays, you are responsible for all fees.

Appointment Cancellation Policy:

Please help us to deliver the best quality dental care by keeping scheduled visits. If you are unable to keep your appointment give at least 24 hours notice. We reserve the right to charge \$50 per hour for appointments cancelled with less than adequate notice.