**Shannon M. Coen DMD**

16080 N. 59th Avenue, Suite A

Glendale, AZ 85306

602-978-1100

**New Patient Information**

Patient’s Name: Date of Birth:

If Minor, Parent/Guardian Name: Date of Birth:

Social Security Number: Driver’s License Number:

Address:

City: State: Zip Code:

Cell Number: Home Number:

Work Number: E-mail:

**Please check how you want us to confirm your appointments:**

\_\_\_\_ Text \_\_\_\_ E-mail \_\_\_\_Phone Call

Contact Person in Case of Emergency:

Contact Phone Number:

How did you hear about our office:

**HIPPA**

I authorize disclosure of my protected health information to specific individual(s) listed below:

I have read and understand the patient privacy notice and am aware I may request a printed copy for myself. If I have any questions I have asked and they have been answered to my satisfaction.

I give permission to Dr. Coen to do any necessary examinations and dental radiographs as needed.

Signature: Date:

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**Financial Arrangements At Our Office**

Thank you so much for choosing our office to be your dental home. We look forward to treating you.

Please review the Financial Policies for our office.

* Payment is due at the time of service
* We accept Cash, Debit Cards, Credit Cards, and CARE Credit.
* We do not have cash in our office so any change or refunds will be mailed to you or given to you at your next appointment
* We do our best to verify your coverage by your insurance. You will be responsible for what you insurance does not cover.
* Treatment plans are only an estimate of what your insurance may pay. If you truly want to know your exact cost for the treatment we would need to authorize your treatment with your insurance company prior to your treatment being done in our office. You will be billed for any additional costs after your insurance company pays for services rendered.
* Twenty-four hours notices are needed for cancellation or rescheduling of a dental appointment at our office. If you do not give twenty-four hours notice for a cancelled/rescheduled appointment we reserve the right to charge you a $35 fee.

I (We) the undersigned, herby agree to pay all amounts and charges incurred by myself and member of my family for services rendered by Dr. Shannon Coen according to the financial policies established.

In the event that Dr. Shannon Coen agrees to file insurance claims for myself of my family, I authorize the release of dental information necessary to process that claim and request that payment of benefits be made to Dr. Shannon Coen. I further agree to pay an amount not covered by my insurance company.

Signature: Date: