**Jonathan E. Greene, DDS**
**65 Sachem Street**
**Norwich, CT 06360**
**(860) 889-8427**

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We are truly caring about our patients and want you to feel very comfortable with our entire team.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ We work with only one patient at a time. The time that you reserve with us is yours and yours alone.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.
- ✓ Our office offers the latest advances in technology, including digital x-rays, intraoral cameras, flat screen televisions and music for your use during your appointment.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you.

Enclosed you will find our new patient information forms. Please fill this out and bring it with you to your first appointment along a with a list of any medications that you take. We look forward to meeting you.

Sincerely,

Jonathan E. Greene, DDS & Greene Dental Group Team

P.S. Please visit our website at www.greenedentalgroup.com to learn more about us!

Greene
Dental Group

## FINANCIAL & APPOINTMENT GUIDELINES

Thank you for choosing **Greene Dental Group, LLC** as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Our team is eager to serve you and help you with your dental needs and concerns. We strive to make your dental experience with us comfortable and caring.

### Payment & Insurance Policy:

To ensure a good relationship, **payment is due at the time service is provided.** For treatment completed in a single visit, payment is expected at the time of service. For treatment requiring multiple visits, 50% down is due at or before the first appointment, and the remaining balance is due at the time completion of treatment is provided.

We will be happy to assist you in filing a dental claim and determining what your optimal dental benefits might be. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract, and therefore we never guarantee insurance benefits. Estimates of insurance payments by this office are subject to insurance company changes. The entire fee is the responsibility of the patient. We accept Cash, Check, Visa and MasterCard, American Express, and Discover. If you wish to apply for our extended payment plan with Care Credit, please ask a member of our financial team for details. Returned checks, and overdue accounts will be subject to additional fees.

### Cancellation & Late Policy:

Appointments are the responsibility of the patient. We reserve a time for you with our providers and ask that you respect their time. If you are late for your appointment, please contact us as soon as possible so that we may advise you if your late arrival can be accommodated. For cancellation, we require **AT LEAST 24 hours advanced notice.** Should you need to contact us after hours to reschedule, an auto attendant and voicemail is available for you to leave a message. Failure to notify us may result in a $60.00 broken appointment fee.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care and our policies. We strive to give you and your family the best dental care possible and appreciate your help in making this relationship mutually successful.

**REGARLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BALANCE, AND I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.**

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**Signature (Patient, Guardian, or Responsible Party)** **Date**