

Patient Information

Name:

Last	First	MI
Male or Female	_ Married_ Single_ Child_ Other	_____

Birth Date: _____ SS#: _____ - _____ - _____

Phone (Home): _____ (Cell): _____

(Work): _____ Ext: _____

Email address: _____

Mailing address: _____

Street	Apt#	
_____	_____	
City	State	Zip Code

Employer Name: _____

Address: _____

Street	City	State	Zip Code
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Occupation: _____

In case of an emergency, contact (Specify someone who does not live in your household)

Name: _____ Relationship: _____

Phone (Home): _____ (Work): _____

Parent/Guardian Information (if applicable)

Name: _____

Last	First	MI
Male or Female	_ Married_ Single_ Child_ Other	_____

Birth Date: _____ SS#: _____ - _____ - _____

Phone (Home): _____ (Cell): _____

(Work): _____ Ext: _____

Email address: _____

Mailing address: _____

Street	Apt#	
_____	_____	
City	State	Zip Code

Employer Name: _____

Employer Address: _____

City	State	Zip Code
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Occupation: _____

Insurance Information

Primary Insurance Plan Information:

Company Name: _____

Company Address: _____

Company Phone: _____

Name of Insured: _____

Is insured a patient? Yes or No

Insurance ID #: _____

Group #: _____

Secondary Insurance Plan Information:

Company Name: _____

Company Address: _____

Company Phone: _____

Name of Insured: _____

Is insured a patient? Yes or No

Insurance ID #: _____

Group #: _____

Office Use Only:

Copy of card: Yes or No Date Copy Take: _____

Consent for Services

I realize that in spite of the possible complications and risks, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this treatment or procedure.

I have provided as accurate and complete a medical and personal history as possible and will follow any and all instructions as explained to me and directed.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare that patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2 % per month (18%) per annum on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent or guardian: _____

Date: _____ Relationship to Patient: _____