Patient Information

Patient Name: _____
Last, First MI (Preferred Name) Birth date Chart #

Circle one: Male Female Married Single Child Other Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____ Best time to call _____

Home Address: _____
Street Apartment # City State Zip Code

Employer Name _____ Occupation / Job _____ Email _____

Work Address: _____
Street City State Zip Code

Preferred Appointment times and dates: Morning Afternoon Anytime M T W Th F S Referred by: _____

Responsible party

Circle one: Self or parent/guardian If not self, please complete the following:

Responsible party's Name: _____
Last, First MI Birth date Social Security #

Circle one: Male Female Married Single Child Other Best time to call _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address: _____
Street Apartment # City State Zip Code

Employer Name _____ Occupation / Job _____ Email _____

Work Address: _____
Street City State Zip Code

Insurance Information

Circle one: Self-pay or Insurance Patient's relationship to Insured and if not self, then complete the following: Self Spouse Child Other

Name of Insured _____
Last, First MI Birth date Social Security # ID# Group #

Insured's Address: _____
Street Apartment # City State Zip Code

Insured's Employer Name _____ Phone # _____

All Patients: Insurance Plan Name _____ Phone # _____

Authorization and Release:

I authorize the dentist and staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____ **Date** _____

Consent for Services

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 the 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 the patients 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 any insurance company. A service charge not to exceed 1 ½ % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60days, 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 this assignee, at the time said services are rendered, or within(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 content.

Signature of patient (parent / guardian) _____ **Date** _____ **Circle one: self parent guardian**

Signature of guarantor of payment/responsible party, if not patient _____ **Date** _____