Patient Information

Patient Name: ____ Date: _____________________

(Last, First, Middle Initial) (Preferred Name)

Gender: Male-Female Birth Date: ______________ Social Security #:__________________________

(Circle One)

Family/Status: Married-Single-Child-Other ____

(Circle One, write explanation for other)

Address: ____

Street Apartment #

____

City State Zip Code

Phone Number's: Home: ____________________ Work: ____________________ Ext.: ________

Cell: ___________________ Email: ____

Employer: _____________________________ Occupation: _________________________________

Employer Address: ____

Street Apartment/Suite #

____

City State Zip Code

Spouse or Responsible Party Information

This information is for the person responsible for payments, insurance or parent of patient.
(If the patient above is the responsible party member skip to the next section.)
Name: ____

(First, Last, M.I.) (Preferred Name)

Gender: Male-Female Birth Date: _______________ Social Security #:_________________________

(Circle One)

Employer Name: ______________________________ Occupation: ___________________________

Employer Address: ____

Street Apartment/Suite#

____

City State Zip Code

Insurance Information
Primary

Insurance Plan Name: ____

Insurance Address: ____

Street City, State, Zip Code

Group Number: _________________________ Subscriber I.D.: ______________________________

Secondary Insurance

Subscriber Name: ____

Subscriber Relationship to Patient: Self-Spouse-Child-Other______________________________

(Circle One)

Insurance Plan Name: ____

Insurance Address: ____

Street City, State, Zip Code

Group Number: ________________________ Subscriber I.D.: _____________________________

Referral Information

Whom may we thank for referring you to our practice? (Please include a name if it is a person)

____

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 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 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 an insurance company. Also for IV sedation reservations our policy is to pay in advance for this service and that it is nonrefundable if canceled in less than two weeks in advance.

A service charge of 1 ½% 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 authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for the proper dental care. I authorize payment of medical and dental benefits to the undersigned dentist for services prescribed/preformed.

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 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 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 conditions of the treatment and agree to their content.

X____ Date: _______________

(Signature of patient, parent or guardian)