PATIENT INFORMATION as of ____________________(Date)

Name: First: ____________________MI:____ Last: ______________________ Date of Birth: ____________

Marital Status: Married – Single – Divorced – Other **Gender:** M / F

Address: ____SSN:___________________________

Address: ____ Nickname: ______________________

City/State/Zip: City: __________________________ State: ___________Zip:____________________________

Home #_____________________________ Email Address: __________________________________

Work#:_____________________________ **Emergency Contact:**

Fax#:______________________________ First Name: ______________________________

Mobile#:____________________________ Last Name: ______________________________

Referred by :________________________ Phone Number:___________________________

GUARANTOR INFORMATION (if different from patient)

Name: First: ____________________MI:________ Last: _______________________ Date of Birth: ___________

Address: ____SSN:______________________________

Address: ____ Nickname: _________________________

City/State/Zip: City: _________________________ State: __________Zip:________________________________

Home #_____________________________ Email Address: _____________________________________

Work#:_____________________________ Fax#:____

Mobile#:_____________________________ Relationship to patient________________________________

DENTAL INSURANCE (if applicable)

Name of Insurance: ____ **Group #**: ____________________________

Subscriber's Name: ____**SS# or ID#**___________________________

Employer Name: ____ **Date of Birth:** ________________________

Telephone Number ____________________________________

PLEASE READ AND SIGN BACK OF FORM

We hope you have had a chance to review our web site and informational CD and allow it to guide you to better health. In order to precisely assess your oral health, we will gather some pertinent information. A thorough health history will be necessary to insure safe treatment and to accommodate your individual physical state. Models of your oral structures, radiographs (x-rays) and photographs may be required. These items and the contents of your record will remain the property of the dental practice.

You will receive H.I.P.P.A. (Health Information Personal Privacy Act) forms that will detail your rights to access these records from the office. Models, x-rays, or photographs may be shown to other professionals for education purposes, but your identity will never be revealed. Your signature constitutes agreement with these policies and permission to exercise these policies.

It also requires you to pay all fees and charges for treatment the day they are incurred, unless alternative arrangements have been made in advance. (Credit inquiries may be made to facilitate those arrangements.)

Amounts due over 60 days are subject to a 1.67% service charge (20% annually). In the event this account is turned over to an attorney for collection, the signatory agrees to pay 33 1/3% attorney fees in addition to all sums owed. If we are unable to guarantee the check for any reason, an alternative payment arrangement will be required. Authorization of refund can take up to 45 days to process.

If you have dental insurance that you feel may cover some of the treatment, we can assist you in obtaining a pre-treatment estimate from your insurance company to determine possible benefits. Your signature on the appropriate H.I.P.P.A. forms will authorize the release of necessary information to process any claims on your behalf and will allow us to assign any realized benefits to the practice.

If presenting an insurance card for possible dental benefit, you will need to provide us with the insurance card and a photo id which will be copied and remain in the chart for the duration of your treatment here.

A missed appointment is a loss to everyone. It is therefore our policy to charge $155.00 for appointment not cancelled 24 hours prior to the appointment. The charge for a missed general anesthesia appointment is $1,000.00. These fees will offset the cost of set up of room and supplies which will need to be discarded.

We require all financial arrangements to be completed before treatment begins so we can the concentrate on providing the best possible care to you.

Our office accepts: Cash, Personal checks, Visa and Master Card, American Express, and Discover. Dishonored or returned checks will incur additional charges of $35.00.

Your signature below indicates that you understand and agree to the policies described above and have answered the information on the front of this form truthfully.

Signature: ______________________________ **Date:** ____________________