Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: ☐ Married ☐ Single ☐ Child

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext:_____ E-Mail: _____

Address: _____
Street Apartment #

_____

Person to contact for emergency: _____ Telephone _____

Is another member of your family or relative a patient at our office? _____

Who may we thank for referring you to our office? _____

Responsible Party Information (if different than above)

Relationship to Patient: ☐ the patient's spouse ☐ parent or guardian ☐ other, _____

Name:_____
☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Telephone: _____

Insurance Information

Please allow us to copy your Insurance Card

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.

Unlike medical offices where you come in and "wait your turn", we schedule appointment times specific to your treatment needs. These times are reserved just for you. If you do not give us adequate notice that you are unable to come – your appointment time is left open and someone who would have liked to come in, would not have been able to do so. Unless a scheduled appointment is cancelled 24 hours in advance, you will be billed $59.00 for the missed appointment of one hour or less, and $118.00 for a missed appointment of more than one hour.

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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A minimum billing charge of $4.90 applies. I understand that fee estimates listed for 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 content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian