PATIENT INFORMATION

(This information is necessary for our files and will be considered ***CONFIDENTIAL)***

Date _____

Patient's Name _____ (LAST / FIRST / INITIAL) Age ____ Patient's Birthday _____ ❑ Male ❑ Female

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ (STREET / CITY / ZIP) For how long? _____ ❑ Own ❑ Rent

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor Email _____

Driver's License No. _____ Social Security No. _____ Res. Phone ( ) _____

Bank _____ Account No. _____ How long? _____ Cell Phone ( ) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ (STREET / CITY / ZIP) Res. Phone ( ) _____

❑ I have no physician

Name of Physician _____ (ADDRESS / CITY) ( ) (TELEPHONE)

Former Dentist _____ (ADDRESS / CITY) ( ) (TELEPHONE)

Why are you changing dentists? _____

Purpose of Appointment _____ Do you wish to speak to the doctor privately? ❑ Yes ❑ No

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ ( ) (TELEPHONE)

Address _____ (STREET / CITY / ZIP) ( ) (CELL PHONE)

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. _____ (EXPIRATION DATE)

❑ State Aid No. _____ ❑ Mastercard No. _____ (EXPIRATION DATE)

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO. _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO. _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

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

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, 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 agree to their content:

Signed _____ Date _____