PATIENT INFORMATION

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

Patient's Name ______________________ Age ________ Spouse's Name ________
LAST FIRST INITIAL

If patient is a minor, give parent's or guardian's name: ______________________

Residence Address ______________________
STREET CITY ZIP

E-Mail Address ______________________

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Driver's License No. ________ Social Security No. ________ Res. Phone ________

Bank ________ Account No. ________ Patient's Birthdate ________

Employed by ________ Occupation ________

Business Address ________ Bus. Phone ________ EXT.

Spouse Employed by ________ Occupation ________

Business Address ________ Bus. Phone ________

Name of nearest relative not living with you: ________ Relationship ________

Complete Address ________ Res. Phone ________

Name of Physician ______________________
ADDRESS CITY TELEPHONE

Former Dentist ______________________
ADDRESS CITY TELEPHONE

Purpose of Appointment ______________________

if this office visit for Emergency Dental Care? ______________________

School Children Attend ______________________

Whom may we thank for referring you? ______________________

FINANCIAL INFORMATION

Person responsible for this account: ________ Relationship ________

Address ______________________
STREET CITY ZIP TELEPHONE

PREFERENCE OF PAYMENT

☐Cash on day of treatment ________ ☐ Dental Insurance (Name of Co.) ________

☐ VISA No. ________ Insurance Group No. ________

☐ Mastercard No. ________ Soc. Sec. No. of Insured ________

☐ State Aid No. ________ ☐ Other ________

TERMS & CONDITIONS

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 service performed without prior 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 patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patients 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) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

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 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 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: ________