Patient Information

(This information is necessary for our files and your health and will be considered CONFIDENTIAL) Date: _____

Name _____ Age _____ Date of Birth _____

Last First Middle SSN _____

Home Address (Street) _____

_____

City State Zip

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Home Phone _____ Cell Phone _____ E-Mail Address _____

Employer _____ Business Phone _____

Employer's Address _____

Spouse (or Parent, if patient is under 18) _____ DOB _____ SSN _____

Employer (for above) _____ Business Phone _____

Employer's Address _____

Emergency Contact _____ Relationship _____

Contact's Address _____

City _____ State _____ Zip _____ Home Phone _____

Medical Doctor _____ Phone _____

Doctor's Address _____

Has any member of your family been a patient in this office? Yes No

If so, please state their name(s): _____

How were you referred? _____

Purpose of today's appointment: _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ Phone _____

Payment preference:

☐ Cash (on day of treatment) ☐ Credit Card ☐ Check

Credit Card Information:

☐ Master Card ☐Visa ☐Discover

Card No. _____ Expiration Date _____ CSC (3 digit code) _____

TERMS AND CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from 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 dental office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit any 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.

I understand that the fee estimated for this dental care can only be extended for a period of six months from the date of the patient examination.

I agree that payment is expected when services are rendered unless prior written financial arrangements have been made. I further agree to pay the account balance within seven (7) days of billing if credit shall be extended. In the event that this account balance becomes past due, the doctors, his assigns, or lawful agents may immediately consider the account in default and pursue collection procedures. If my account is past due I agree to pay 1 ½ % interest per month (18% per annum) on the unpaid balance from the date due, in addition to collection costs. Collection costs may include, but are not limited to court filing fees, service of process costs, and attorney's 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.

Signature: _____ Date: _____