Patient Information

Date _____

Patient's Name _____
Last First Initial Preferred Name

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ Birthdate _____

E-mail Address _____ Social Security # _____

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

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

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip Code

Mailing Address _____
Street City State Zip Code

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip Code

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____ 's dental needs. (name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistant as required to provide proper care.

3. I agree to the use of anesthetics, sedative, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. A complete list of possible adverse reactions are available upon request.

FINANCIAL POLICY

Sound financial arrangements enable us to deliver more needed dental care to our patients and helps us to keep our fees stable while providing quality dental care.

1. Payment is due on the day services are rendered unless prior financial arrangements have been made. _____ (initials)

2. Our office will gladly submit dental insurance claims. We expect you to pay your estimated portion of the bill on the day of service, unless prior financial arrangements have been made.

Remember, your insurance is a contract between you, your insurance company and your employer. We will file a claim as a service to you but can not guarantee payment of your claims even if a pre-determination of benefits has been received. If insurance reimbursement is not received within 45 days of the original date of service you will be billed for the entire balance. _____ (initials)

3. For treatment plans that require a large financial investment in your dental health, feel free to discuss with us the payment plans we have available. For your convenience we accept Cash, Check, Visa, MasterCard and Discover. Additional financing may be available through Capital One, Dental Fee Plan. _____ (initials)

4. A cancellation fee of $20 - $60 will be charged if the appointment is cancelled with 24 hours of the scheduled time. The fee assessed will depend on the amount of time scheduled. _____ (initials)

5. A charge of $27.50 will be assessed for all returned checks. If we are charged additional fees by our financial instituation in excess these fees will be assessed to your account. _____ (initials)

6. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependent. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge may be added to my account. Late fees are assessed monthly as follows:

ON ACCOUNT BALANCES OF : 0.00 - $100.00 - $3.00 late fee
$100.01 - $299.99 - $5.00 late fee
$300.00 - $499.99 - $7.00 late fee
$500.00 - over - $10.00 late fee

In addition I, the undersigned assume and agree to pay for all collection costs incurred while attempting to collect the amount due (these costs may include but are not limited to attorney fees, collection agency fees, court costs, and interest which will be charged at an annual percentage rate (APR) of 21% / 1.75% per month). _____ (initials)

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____