

Scott L. Tamura DMD  
**PATIENT INFORMATION**

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

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Patient Birthdate: \_\_\_\_\_

If patient is a minor give name of parent or legal guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Present Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ For how long: \_\_\_\_\_ Rent \_\_\_\_\_ Own \_\_\_\_\_

Patient is: Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_ Widowed: \_\_\_\_\_ Minor: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cel Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ How Long: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Drivers License State: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Bank Name: \_\_\_\_\_ Account Number: \_\_\_\_\_ How Long: \_\_\_\_\_

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Spouses Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Employed by: \_\_\_\_\_ How Long: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERING YOU?** \_\_\_\_\_

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**FINANCIAL INFORMATION**

Person Financially Responsible for this account: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Preference of payment:**

Cash on day of treatment: \_\_\_\_\_

Credit Card: MC \_\_\_\_\_ Visa \_\_\_\_\_ Amex \_\_\_\_\_ Discover \_\_\_\_\_ Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

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**TERMS AND 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 for all dental services. If I carry dental 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 any benefits accruing to me under my policy.*

A service charge of 2.33% per month (28% per annum or the maximum rate permissible under California State law) will be charged on the unpaid 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 three 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 (5) business 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 legal proceedings with respect to amounts owed by me for services rendered, the prevailing part in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys fees.

I have read the above conditions of treatment and agree to their content:

Patient/Guardian (Signature): \_\_\_\_\_ Date: \_\_\_\_\_