Referral Information

Whom may we thank for referring you to our practice? __ Another patient, friend __Relative
__Dental Office __Yellow Pages __Newspaper __School __Work __Other _____
Name of person or office referring you to our practice:_____

Employment Information

The following is for: __the patient __the person responsible for payment
Employer Name: _____ Occupation:_____
Address:_____
_____

Insurance Information

Name of Insured:_____ Is insured a patient? __Yes __No
Insured's Date of Birth:_____ ID#_____ Group#_____
Insured's Address:_____
Insured's Employer Name:_____
Address:_____
Patient's relationship to insured: __Self __Spouse __Child __Other_____
Insurance Plan Name and Address:_____
_____
Insurance Plan Phone #:_____

Consent for Services

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 services performed without previous financial arrangements, must be paid for in cash at the time services are preformed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and the he or she in personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or 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.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me. Or at my request, by the Doctor, 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 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 assignee, to telephone me at home or at my work to discuss matter related to this form.

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

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient:_____
Signature of guarantor of payment/responsible party