Patient Information
(PLEASE PRINT)

Patient

Name: _____ Birth Date: _____/_____/_____
Last First Middle

Referred By: _____

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

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____ ____

SSN#:_____ Home Phone: _____ Cell Phone: _____

Employer: _____ Position: _____ Bus. Phone: _____ _____

Bus. Address: _____ City: _____ State:_____ Zip:_____

Email Address: _____

Who should be notified in case of emergency? _____ Phone: _____

Name of nearest relative not living with you: _____ Phone: _____

Purpose of this appointment: _____

SPOUSE OR PARENT

Name: _____ Birth Date: _____/_____/_____
Last First Middle

Employer: _____ Position: _____ Bus. Phone: _____ _____

Bus. Address: _____ City: _____ State:_____ Zip:_____

SSN#:_____ Home Phone: _____ Cell Phone: _____

Email Address: _____

INSURANCE INFORMATION

Do you have insurance? ☐Yes ☐ No If yes, complete the following:

Name of the insured: _____ SSN#:_____ Relationship_____

Date of Birth: _____/_____/_____ Insurance Company_____ Group# _____

Is patient covered by other Insurance? ☐Yes ☐ No If yes, complete the following:

Name of the insured: _____ SSN#:_____

Relationship_____ Date of Birth: _____/_____/_____ Insurance Company_____

Group#_____

TERMS & 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 patient for the cost 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 service is performed, I understand that the dental service furnished to me are charged directly to me and that I am responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from my 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. A service charge of 1.5% per month (18% per annum) but in no event more than the maximum rate permissible under state law will be charged on the unpaid balance on all accounts not paid within 60 days of the treatment date. I understand that the fee estimate listed for this dental case can only be extended for period of six months from the date of patient's examination. In consideration of the professional services rendered to me, or my request, by the Doctor and/or staff, I agree to pay. Therefore, the reasonable value of said services to said Doctor or assignee at the time 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 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 any legal proceeding with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant permission to, or your assigns, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature:_____ Date_____/_____/_____

Print Name:_____