PATIENT INFORMATION

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

Patient's Name: _____ Male Female Date_____

If patient is a minor, state name of legal guardian: _____ Relationship: _____

Address: _____ For how long: _____

Home Telephone: _____ Cell Number: _____ Email Address: _____

Patient is: Minor Single Married Divorced Separated Widowed Birth Date: _____

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Employed By: _____ How long? _____

Address: _____

Phone Number: _____ Ext: _____ Occupation: _____

Name of Physician: _____ Phone Number: _____

Former Dentist: _____ Phone Number: _____

Why are you changing dentist? _____ Students, name of school/college & city: _____

Whom may we Thank for Referring you? Insurance Website Other _____ Friend/Relative _____

FINANCIAL & INSURANCE INFORMATION

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Person responsible for this account: _____ Relationship: _____

Address (if different than above): _____

Home Telephone: _____ Cell Number: _____ Work Number: _____

Name of Primary Insurance Company: _____ Telephone Number: _____

Insured Person: _____ Relationship: _____ Date of Birth: _____

Social Security Member ID: _____ Name of Employer: _____

Name of Secondary Insurance Company: _____ Telephone Number: _____

Insured Person: _____ Relationship: _____ Date of Birth: _____

Social Security Member ID: _____ Name of Employer: _____

TERMS & CONDITIONS

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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 cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. I understand that dental services furnished to me are charged directly to me and that I am personally 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 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 benefits accruing to me under my policy. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of 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. 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 any legal proceedings 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 and/or collection 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:

Signed: _____ Date:_____