PATIENT INFORMATION **Date:**

Patient Name: _____
Last, First MI (Preferred Name, If Different)

*Social Security #: _____ *Birth Date (mm/dd/yyyy): _____

*Social Security number is required for insurance purposes; birth date is required for insurance purposes and/or prescribing medication.

Gender: □ Female □ Male Family Status: □ Single □ Married □ Widowed □ Child

Contact Information: (Please mark which of the below contacts we should use to make our appointment reminder calls)

□Home Phone: (_____) _____-_____ □Work Phone: (_____) _____-_____

□Mobile Pone: (_____) _____-_____ □Email Address: _____

Home Address: Billing Address: (Check box if same as Home Address □)

_____ _____
Street Apt. # Street Apt. #

_____ _____
City State Zip Code City State Zip Code

RESPONSIBLE PARTY INFORMATION

Check box if same as patient information □

Name: _____
Last, First MI Relationship to the Patient

*Social Security #: _____ *Birth Date (mm/dd/yyyy): _____

*Social Security number is required for insurance purposes; birth date is required for insurance purposes and/or prescribing medication.

Gender: □ Female □ Male Family Status: □ Single □ Married □ Widowed

Contact Information: (Please mark which of the below contacts we should use to make our appointment reminder calls)

□Home Phone: (_____) _____-_____ □Work Phone: (_____) _____-_____

□Mobile Pone: (_____) _____-_____ □Email Address: _____

Home Address: Billing Address: (Check box if same as Home Address □)

_____ _____
Street Apt. # Street Apt. #

_____ _____
City State Zip Code City State Zip Code

EMERGENCY CONTACT INFORMATION**

Name: _____ Home Phone: (_____) _____-_____

Relationship to the Patient: _____ Cell Phone: (_____) _____-_____

**We will contact this person in the event of a medical emergency.

REFERRAL INFORMATION

Whom may we thank for your referral to our practice? _____

Contact information if referral source is not a patient of our practice: _____

INSURANCE INFORMATION

Primary (Check if None □) Secondary (Check if None □)

Name of Insured: _____ Name of Insured: _____

Insured's Address: _____ Insured's Address: _____

Relationship to patient: _____ Relationship to patient: _____

Insured's DOB: _____ ID #: _____ Insured's DOB: _____ ID #: _____

Group #: _____ Group #: _____

Insured Employer Name: _____ Insured Employer Name: _____

Insured Employer Address: _____ Insured Employer Address: _____

_____ _____

Insurance Plan Name: _____ Insurance Plan Name: _____

Insurance Address: _____ Insurance Address: _____

Insurance Phone: _____ Insurance Phone: _____

Consent for Services

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

The undersigned also authorizes the doctor to perform all recommended treatment mutually agreed upon by the undersigned and to use the appropriate medication and therapy indicated for such treatment.

As a condition of the patient's 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 performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is 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 patient's 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 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 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 three months from the date of the patient examination.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS
I authorize the health care provider to submit claims for payment for services to the health care service plans or insurance companies named above, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

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

Signature of patient, parent or guardian	**Date**	**Relationship to Patient**

Signature of guarantor of payment/responsible party	**Date**	**Relationship to Patient**