Patient Information

Patient Name ____ **Date** ____________
Last First MI (Preferred Name)

Gender:______ **Family Status:** ________

Social Security # ____________________________ **Birth Date:** ____________________________

Phone (Home) _____________ **(Work)** ________________ **Ext.:**______ **Best time to call:**_______

Cell Phone # _______________ **(Other)** ____

Address: ____
(Street) (Apartment #)

____
(City) (State) (Zip Code)

Employer Name: ____________________________ **Occupation:**_________________________

Address: ____
(Street) (City) (State) (Zip Code) Phone #

May we contact you by E-Mail to confirm your appointments? ☐ **Yes** ☐ **No**

If so, what is your E-Mail address: ____

Who may we contact in case of Emergency: ____________________ **Phone#** _______________

Responsible Party (Guarantor) Information
(if different from above)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________________________

Social Security # _________________________________ **Birth Date:**______________________

Phone (Home):_______________ **(Work):**_____________ **Ext:** _______ **Best time to call:**_______

Address: ____
(Street) (Apartment #)

____
(City) (State) (Zip Code)

Employer Name: ____________________________ **Occupation:**_________________________

Address: ____
(Street) (City) (State) (Zip Code) Phone #

Dental Insurance Information

Primary Information:

Name of Insured: __________________________________ **Is insured a patient?** ☐ **Yes** ☐ **No**
(Last) (First) (MI)

Insured's Birth Date: _________ **ID#** ___________ **Group #** _________ **SS#**___________________

Insured's Address: ____
(Street) (City) (State) (Zip Code)

Insured's Employer Name: ____

Address: ____
(Street) (City) (State) (Zip Code)

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** __________________

Insurance Plan Name and Address: ____

____

Secondary Insurance Information

Name of Insured: __________________________________ **Is insured a patient?** ☐ **Yes** ☐ **No**
(Last) (First) (MI)

Insured's Birth Date: ____________ **ID#** ___________________ **Group #** ___________________

Insured's Address: ____
(Street) (City) (State) (Zip Code)

Insured's Employer Name: ____

Address: ____
(Street) (City) (State) (Zip Code)

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** __________________

Insurance Plan Name and Address: ____

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:______________________________

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, of any dental services performed without previous financial arrangement, must be paid for with cash, check, or credit card 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 90 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 six months from the date of the patient examination.

In consideration of 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 were instituted hereunder.

I grant my permission to you or your assignee, 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 payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ________________
Signature of Patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ________________
Signature of Patient, parent or guardian

Payment Authorization
Signature on File

- ☐ **I authorize use of this form on all my insurance submissions.**
- ☐ **I authorize release of information to all my insurance carriers.**
- ☐ **I understand that I am responsible for my bill.**
- ☐ **I authorize my Doctor to act as my agent in helping me obtain payment from my insurance carriers.**
- ☐ **I authorize payment directly to my Doctor.**
- ☐ **I permit a copy of this authorization to be used in place of the original.**

Name: (Print)
____

Signature:
____Date:_____________________