

Patient Information

Patient Name _____ Preferred Name _____
Last First MI
Gender (male/female) Check Appropriate Box: married single divorced widowed separated
Birth Date: _____ Soc. Sec# _____ Driver's License # _____
Address: _____
Street City State Zip Code
Email Address _____
Phone #'s: Home _____ Work _____ Cell _____ Best time to call _____

Referral information

Whom may we thank for referring you?

Friend/Relative Existing Patient Dental Office Yellow pages Newspaper 501
Insurance company Physician/Dentist Facebook Internet KVOM Y107

REFERRED BY: _____

Spouse or Responsible Party Information

Name: _____ Gender (male/female)
Last First MI
Birth Date: _____ Soc. Sec# _____ Driver's License # _____
Address: _____
Street City State Zip Code
Email Address _____
Phone #'s: Home _____ Work _____ Cell _____ Best time to call _____
Employer
Name Address City State Zip Code

Employment Information

Employer Name: _____ Employer # _____
Address: _____
Street City State Zip Code

Insurance Information

Name of Insured _____
Last First MI
Insured's Birthdate: _____ Soc. Sec# _____
ID# _____ Group # _____
Employer _____
Patient relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary

Name of

Insured _____
Last First MI

Insured's Birthdate: _____ ID# _____ Group# _____

Employer _____

Patient relationship to insured: self Spouse Child Other _____

Insurance Plan Name and Address: _____

I will be paying today by: Cash Check Credit Card Care Credit

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. Financial responsibility on the part of each patient must be determined before treatment. We require an appointment confirmation at least **24 hours in advance or your appointment could be canceled**

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 patient's insurance forms or assist in making collections from insurance companies and will credit any such collection 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.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. If further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

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's 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 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for a payment thereof. 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 the suit is instituted hereunder. In the event of unpaid debt, the guarantor will be subject to a minimum of 40% and a maximum of 50% in addition to the amount owed by the patient/guarantor

I grant 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.

Signature of Patient or Guardian **Date**

I give permission to release any protected information to the following people: _____

I give permission to the following people to accompany my dependent(s) to his/her dental appointment:
