



Patient Information

Patient Name: _____ Sex: M F
Last First MI (preferred name)

Marital Status: _____ Birth Date: _____ Social Security # _____

Address: _____
Street City State Zip

Phone Numbers: () () ()
Home Work Cell

Preferred Contact Method: Home Work Cell

Email Address: _____

Whom may we thank for referring you to our practice? _____

Insurance Information

Insurance Subscriber: _____
Last Name First MI Birth Date

Is subscriber a patient? Y N
Subscriber SS# Subscriber ID#

Subscriber's Address: _____
(if different) Street City State Zip

Subscriber's relationship to patient: Self Spouse Child Other

Employer's Name: _____
Group#

Employer's Address: _____
Street City State Zip

Insurance Plan Name: _____
Subscriber's #

Insurance Address: _____
Street City State Zip

Insurance Phone: () _____

Is Patient covered by additional dental insurance? Y N
(if yes an additional form should be completed)

Dependant Student Status: _____ Name of School: _____ Full time Part Time

Consent for Treatment, Insurance Payment Authorization and Financial Policy Disclosure

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party of insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collections from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a fee for appointments missed or cancelled with less than 24 hours advance notice. This office reserves the right to charge interest of APR = 12% for overdue balances. In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to the Doctor or his assignee, at the time services are rendered or within 15 days of billing if credit is 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 agree to pay all costs of collection, including attorney's fees and expenses, incurred to collect any unpaid fees.

Signature: _____ Date: _____