W O L F DDS

general, cosmetic & implant dentistry for adults

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PATIENT INFORMATION

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

Marital Status: _____ (please select one) Birth Date: _____ (mm/dd/yyyy) SSN _____

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

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

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

Email: _____

Preferred Contact Method: Phone ☐ _____ (please select one) Email ☐ Text ☐ _____ (name of wireless carrier)

Emergency Contact Person: _____ (Name) _____ (Phone)

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

INSURANCE INFORMATION

Insurance Subscriber: _____ Birth Date: _____ (mm/dd/yyyy)

Is subscriber a Patient? Yes ☐ No ☐

Subscriber's SSN _____ Subscriber's ID# _____

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

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other _____

Employer's Name: _____

Employer's Address: _____ (Street) _____ (Town) _____ (State) _____ (Zip)

Insurance Plan Name: _____ Group # _____

Insurance Address: _____ (Street) _____ (Town) _____ (State) _____ (Zip)

Insurance Phone: ( ) _____

Is Patient covered by additional dental insurance? Yes ☐ No ☐ If Yes, an additional form should be completed.

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 or 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 collection 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 appointment missed or canceled with less than 24 hours advance notice. This office reserves the right to charge interest of APR = 12% for overdue balances or a billing fee of seventy five cents. Inconsideration 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 _____