PERSONAL INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

DATE:_____

[ ] Single
[ ] Married
[ ] Widowed

PATIENT INFORMATION

Name: _____Age: _____ Sex: _____
Last First MI

Name you go by: _____ Date of Birth: _____ Social Security # _____-_____- _____

Home Address: _____
Street Apt # City State Zip Code

Your Driver's License # _____State & Expiration Date _____ Home Phone (_____)_____

Work Phone (_____)_____ Ext. # _____ Email _____

Cell (or Pager)(_____)_____Best Phone Number to Contact You: [ ] Home [ ] Work [ ] Cell/pager

Occupation: _____ Employed by: _____ How Long? _____

Work Address: _____
Street Apt # City State Zip Code

Insurance Company: _____Phone (_____)_____ Group #_____

Person to Contact in an Emergency: _____ Phone # (_____)_____

Closest Relative Not Living With You: _____ Relationship: _____

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

Have you been a patient here before? [ ] Yes [ ] No If yes, when? _____

Is another member of your family a patient here? [ ] Yes [ ] No Who? _____

How did you hear about us? [ ] Family [ ] Friend [ ] Internet [ ] Insurance
[ ] Other _____ [ ] Car Magnet [ ] Website [ ] Google [ ] Postcard

SPOUSE INFORMATION

Name: _____Date of Birth: _____ SS# _____-____-_____

Home Address: _____
Street Apt # City State Zip Code

Occupation: _____ Employed by: _____ How Long? _____

Work Address: _____
Street Suite # City State Zip Code

Work Phone (_____)_____ Ext. # _____ Cell (or Pager) (____ _)_____

Insurance Company: _____ Phone (___ __)_____ Group # _____

ACCOUNT INFORMATION

Bill will be paid by [ ] cash [ ] check [ ] charge [ ] insurance [ ] other _____

Person Responsible for Account _____ Relationship_____

Billing Address: _____
Street Apt # City State Zip Code

Bank _____ Checking Account # _____ Saving Account # _____

Branch Address _____
Street City State Zip Code

TERMS AND CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. My practice depends upon payment 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 service performed without prior 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 to assist in making collections from insurance companies and will credit 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 rebilling fee of $35.00 will be charged on the unpaid balance on all accounts exceeding 30 days unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental treatment can only be extended for a period of 120 days from the date of the patient's examination. If it becomes necessary to miss a scheduled appointment we require a 36-hour notice. THERE WILL BE A CHARGE FOR BROKEN APPOINTMENTS.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or stage I agree to pay the reasonable value of such services to the Doctor at the time the services are rendered or within five (5) days of billing if credit is extended. Additionally, I agree that a waiver of any breach of any term or condition 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 be instituted.

I grant my permission to you, or your employees 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 agree to their content.

Signed: _____ **Date:** _____