PATIENT INFORMATION

PLEASE PRINT THE FOLLOWING PERSONAL INFORMATION

PATIENT'S NAME _____ LAST _____ FIRST _____ MIDDLE _____

❒ SINGLE
❒ MARRIED
❒ DIVORCED
❒ SEPARATED
❒ WIDOWED

RESIDENCE ADDRESS _____ STREET _____

CITY _____ ZIP CODE _____

HOME TELEPHONE _____ DATE OF BIRTH _____ AGE _____

PATIENT EMPLOYED BY _____ BUSINESS TELEPHONE _____

BUSINESS ADDRESS _____ CITY _____ ZIP CODE _____

OCCUPATION _____ HOW LONG _____ SOCIAL SECURITY NUMBER _____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? _____ TELEPHONE _____

Whom may we thank for referring you? _____ **Who is your general dentist?** _____

IF PATIENT IS MARRIED, COMPLETE THIS PORTION

NAME OF SPOUSE _____ OCCUPATION _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ BUSINESS TELEPHONE _____

BUSINESS ADDRESS _____ CITY _____ ZIP CODE _____

IF PATIENT IS A MINOR (UNDER 18), COMPLETE THIS PORTION

PARENT OR PERSON WITH LEGAL CUSTODY _____ OCCUPATION _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ BUSINESS TELEPHONE _____

BUSINESS ADDRESS _____ CITY _____ ZIP CODE _____

PLEASE COMPLETE THE FOLLOWING FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

❒ CASH ❒ CHECK DRIVER'S LICENSE # _____

IF USING CHARGE CARD - NAME _____ CARD NUMBER _____ EXPIRATION DATE _____

NAME OF **DENTAL** INSURANCE COMPANY (Primary Insurance) _____ NAME OF POLICY HOLDER _____ POLICY NUMBER _____

IF CONNECTED WITH UNION – NAME OF UNION _____ LOCAL NUMBER _____ GROUP NUMBER _____

NAME OF **DENTAL** INSURANCE COMPANY (Secondary Insurance) _____ NAME OF POLICY HOLDER _____ POLICY NUMBER _____

IF CONNECTED WITH UNION – NAME OF UNION _____ LOCAL NUMBER _____ GROUP NUMBER _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and / or his staff, 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 the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term of condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

I grant my permission to you, or your assigns, 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:** _____