PATIENT INFORMATION

Patient Name_____Date_____
Last First MI
Male___Female___Child___Single___Married___Other____
Social Security Number_____Date of Birth_____
Address_____
City_____State_____Zip Code_____
Email_____
Phones Home_____Work_____Cell_____
Driver's License #_____State_____
Employer_____
If Student, Name of School/College_____
City_____State_____Full Time_____Part Time_____
Person to contact in case of emergency_____
Phones Work_____Home_____Cell_____
Whom may we thank for referring you to our practice?_____
Friend____Relative____Employer____Insurance Provider List____Yellow Pages_____

RESPONSIBLE PARTY INFORMATION(if not the patient)

Name_____
Relationship to patient Spouse_____Parent_____Legal Guardian_____
Social Security #_____Driver's License #_____State___
Phones Home_____Work_____Cell_____
Address_____
City_____State_____Zip Code_____
Email_____Employer_____
Are you currently a patient in our office? Yes_____No_____

CONSENT FOR SERVICES

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 and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time that services are rendered.

Patients who have dental insurance understand that all dental services provided are charged directly to the patient and he/she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms, send those forms to the insurance company, assist in collection of any portion of the fees that the insurance company covers, and credit any such payments to the patient's account. However, this dental office cannot render services on the assumption that our fees will be paid by any insurance company.

In consideration for the professional services rendered to me, or at my request, by the dentist, I agree to pay the value of said services to said dentist, or his assignee, at the time said services are rendered. 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 attorney fees if suit is instituted hereunder.

I grant my permission to you, or your assignee, to contact me at home, work, or cell to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date_____Relationship to patient_____
Signature of patient, parent, or legal guardian
_____Date_____Relationship to patient_____
Signature of guarantor of payment/responsible party