PATIENT INFORMATION

*(this information is necessary for our files and will be considered **CONFIDENTIAL**)* Date

Patient's Name	Age	Patient's Birthday	☐ Male ☐ Female
Last First Initial			
If patient is a minor, give name of parent or legal guardian		Relationship	
Residence Address		For how long ?	☐ Own ☐ Rent
Street City Zip			
Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor		Email	
Driver's License No.	Social Security No.	Res. Phone	
Bank	Account No.	How long ?	Cell Phone
Employed by		How long ?	Occupation
Business Address			Bus. Phone
Street City Zip			
Spouse's Name	Driver's License No.	Soc.Sec.No.	
Employed by	How long ?	Occupation	
Business Address		Bus. Phone	
Street City Zip			
Name of nearest relative not living with you		Relationship	
Complete Address		Res. Phone	
Street City Zip		☐ I have no physician	
Name of Physician			
Address City Zip Telephone			
Name of Referring Dentist			
Address City Zip Telephone			
Why are you changing dentists ?		Do you wish to speak to the Doctor privately? ☐ Yes ☐ No	
Purpose of Appointment			
Is this office visit for Emergency Dental Care ? ☐ Yes ☐ No	Yes, explain		
Whom may we thank for refering you			

FINANCIAL INFORMATION

WE DO NOT ACCEPT CHECKS

Person responsible for this amount	Relationship		
			Telephone
Address			
Street City Zip			Cell Phone
PREFERENCE OF PAYMENT: ☐ Cash on day of treatment	☐ Visa No.		
			Expiration Date
☐ State Aid No.	☐ Mastercard No.		
			Expiration Date
Name of insurance company (primary insurance)			
INSURED PERSON'S NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NO.
NAME OF GROUP DENTAL PLAN	GROUP NO.	PLAN NO.	NAME OF UNION LOCAL
Name of insurance company (secondary insurance)			
INSURED PERSON'S NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NO.
NAME OF GROUP DENTAL PLAN	GROUP NO.	PLAN NO.	NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be paid 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 or 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 attorney's and/or collection 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