

# PATIENT INFORMATION

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

Patients Name \_\_\_\_\_ Age \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
LAST FIRST INITIAL

If patient is a minor, give parent's or guardian's name: \_\_\_\_\_ Relationship \_\_\_\_\_

Residence Address \_\_\_\_\_  
STREET CITY ZIP

Married  Single  Divorced  Separated  Widowed

Cell Phone No. \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Res. Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Patient's Birthdate \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ EXT.

Business Address \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Relationship \_\_\_\_\_ EXT.

Complete Address \_\_\_\_\_ Res. Phone \_\_\_\_\_

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_

Date of last visit \_\_\_\_\_  
STREET CITY TELEPHONE

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of your last dental xrays \_\_\_\_\_  
STREET CITY TELEPHONE

Purpose of today's appointment \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## FINANCIAL and INSURANCE INFORMATION

### PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Cash on day of treatment

VISA  American Express  Discover  Mastercard

Card No. \_\_\_\_\_

Dental Insurance \_\_\_\_\_  
(Name of Co.)

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Group No. \_\_\_\_\_

Employer \_\_\_\_\_

Name of Insured \_\_\_\_\_

Soc. Sec. No. of Insured \_\_\_\_\_

I have reviewed and received a copy  
(if requested) of the Dental Materials  
Fact Sheet and the HIPPA Compliance Standard.

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)

## TERMS & CONDITIONS

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 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.

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 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 reasonable attorney fees if suit be instituted hereunder.

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: \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES!**