## Patient Information

Name:_____ DOB:_____
Last First MI

Social Security #_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Phone: (H)_____ (C)_____ (W)_____

Address:_____
Street Apt # City State Zip Code

If patient is a student, please list the school:_____

## Spouse or Responsible Party

Name:_____ DOB:_____
Last First MI

Social Security #_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Phone: (H)_____ (C)_____ (W)_____

Address:_____
Street Apt # City State Zip Code

## Dental Insurance Information

Primary
Name of Subscriber:_____ DOB:_____
Last First MI

Address:_____
Street Apt # City State Zip Code

Is subscriber a patient? ☐ Yes ☐ No Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer & Address:_____

DOB:_____ ID #_____ Group #_____

Plan Name:_____ Address & Phone #_____

Secondary
Name of Subscriber:_____ DOB:_____
Last First MI

Address:_____
Street Apt # City State Zip Code

If subscriber a patient? ☐ Yes ☐ No Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer & Address:_____

DOB:_____ ID #_____ Group #_____

Plan Name:_____ Address & Phone #_____

Whom may we thank for referring you to our practice:_____

## Consent for Services

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

**Patients who carry dental insurance understand that he or she is personally responsible for payment for all dental services.** This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any 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 service charge of 1½% (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination. **I also understand that there are fees charged for missed appointments and cancellation of appointments with insufficient notice.**

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) business days of billing if credit shall be extended.

I grant my permission to you or your assignee to contact me at all provided phone numbers to discuss matters related to this form. In the event that I am referred to other dental specialists, I also grant permission for the transfer of my x-rays to those medical offices.

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

| Signature of patient, parent or guardian | Date | Relationship |
| --- | --- | --- |
| Signature of guarantor or payment/responsible party | Date | Relationship |