## Patient Information

Patient Name_______________________________________________Preferred Name ______________________
Last First MI

Gender (male/female) Check Appropriate Box: □ married □ single □ divorced □ widowed □ separated

Birth Date: ____________________ Soc.Sec#________________________ Driver's License #______________________

Address:
______________________________________________________________________________________________
Street City State Zip Code

Email Address__________________________________________________________________________________

Phone #'s: Home___________________ Work__________________ Cell______________ Best time to call____________

## Referral information

### Whom may we thank for referring you

□ Patient, relative □ Patient, friend □ Dental Office □ Yellow pages □ Newspaper □ Facebook □ Internet □ Other
______________________________________________________________________________________________

## Spouse or Responsible Party Information

Name: _______________________________________________________________________ Gender (male/female)
Last First MI

Birth Date: ____________________ Soc.Sec#________________________ Driver's License #______________________

Address:
______________________________________________________________________________________________
Street City State Zip Code

Email Address____________________________________________________________________

Phone #'s: Home___________________ Work__________________ Cell______________ Best time to call____________

Employer
______________________________________________________________________________________________
Name Address City State Zip Code

## Employment Information

Employer Name:____________________________________ Employer #________________________________________

Address:
______________________________________________________________________________________________
Street City State Zip Code

## Insurance Information

Name of Insured______________________________________________________________________________________
Last First MI

Insured's Birthdate: _______________________ ID#__________________________ Group #______________________

Employer ____________________________________________________________________________________________

Patient relationship to insured: □ Self □ Spouse □ Child □ Other ____________________________

Insurance Plan Name and Address: ______________________________________________________________________
______________________________________________________________________________________________

**Secondary**

Name of Insured ______________________________
Last First MI

Insured's Birthdate: ____________ ID# ____________ Group# ____________

Employer ______________________________

Patient relationship to insured: ☐ self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

______________________________

I will be paying today by: ☐ Cash ☐Check ☐Credit Card ☐Care Credit

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement for the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. We require and appointment confirmation at least 24 hours in advance or your appointment could be cancelled.

All emergency dental services, or any dental services performed without previous 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collection 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.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. If further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as thought the undersigned had personally signed the particular claim.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the profession 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 his assignee, at the time said services are rendered, or within five day of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for a payment thereof. 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 costa and reason able attorney fees if suit be instituted hereunder.

I grant permission to you or you assignee, 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 payment and agree to their content.

______________________________ ____________

**Signature of Patient or Guardian** **Date**

I give permission to release any protected information to the following people: ______________________________

I give permission to the following people to accompany my dependent(s) to his/her dental appointment:

______________________________