

PATIENT INFORMATION

(PLEASE PRINT)

PATIENT Name	FIRST	Age	Birthdate
Referred by	FIRST E-mail		Cell Phone
If patient is a minor, give	parent's or guardian's name		Relationship
	Marital Status: Single		
Address		City	State Zip
S.S. #		D.L. #	Home Phone
Employer		Position	_ Bus. Phone
Bus. Address		City	State Zip
Who should be notified in	case of an emergency		Phone
Name of nearest relative	not living with you		Phone
Purpose of this appointme	ent		
SPOUSE Name	FIRST	Age	Birthdate
Bus. Address		City	State Zip
S.S. #		D.L. #	
INSURANCE INFORMATION - Do you have insurance? Tyes Tho. If yes, complete the following			
Name of Insured		S.S. #	Relationship
Insurance Company		Group No	
Is patient covered by other Insurance? Yes No If yes, complete the following			
Name of Insured		S.S. #	Relationship
Insurance Company		Group No	
TERMS & CONDITIONS			
As a condition of treatment by this office, I understand 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. 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. A service charge of 1½ sper month (18% per annum), (but in no event more than the maximum rate permissible under state law) will be charged in 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 Doctors, 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 ow			
Signed			Date