

Welcome

1 Personal Information

Name _____ Social Security Number _____
Spouse's
Name _____ Patient's Birthdate _____
Address _____ City, State, Zip _____
Employer _____ Referred by _____
E-mail address _____ Sports Interest, Sports, Hobbies _____

2 Responsible Party

Who is responsible for your account?

____ I am (please check and skip to section 3)

Name _____ Soc. Sec. # _____
Relationship to Patient _____ Driver's Lic. # _____
Birthdate _____ Address _____
City, State, Zip _____ Occupation _____
Employer _____ Wk # _____ ext. _____ Hm # _____

3 Telephone

Home # _____ Wk # _____ ext _____ Cell # _____
Where do you prefer to get calls? _____ When is the best time to reach you? _____
Spouse's work # _____ Cell # _____
In the case of an emergency, is there anyone, not living with you, that we may contact?
Name _____ Wk # _____ Home # _____ Cell# _____

4 Insurance Information (Please make sure that our front desk has a copy of you CURRENT insurance card)

5 Financial Arrangements:

Payment is due at the time services are rendered unless there is a written pretreatment estimate on file from your insurance Company. Verbal estimates are not acceptable.... NO EXCEPTIONS.

For your convenience, we offer the following methods of payment. Please check the method(s) you will be using.

____ CASH ____ PERSONAL CHECK* ____ MC/VISA/American Express ____ Financing (Care Credit, Dental Fee Plan)

**(If your check is dishonored or returned for ANY reason, we reserve the right to electronically debit your account for the amount of the check plus a processing fee of \$35.)*

6 Authorization and Release: I authorize the dentist or any of her staff to release any information including records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or other health practitioners. I agree to be responsible for payment of all services rendered on behalf of myself and/or my dependents*.

X _____ Date _____

*If I do not pay the entire balance within 30 days of the service date, a late charge of 1.9% will accrue on any unpaid portion of the balance each month. I also realize that failure to keep this account current will result in our office being unable to provide additional dental services. In the case of default of payment of this account, I agree to pay any collection costs and attorney fees incurred in attempting to collect on this amount or any future outstanding balances. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits unless stated differently on the claim form. I understand that my dental insurance carrier may pay less or nothing of the actual bill for services rendered. I agree to be responsible for payment of ALL services rendered on my behalf or my dependents.