Referred By ____

Patient Legal Name	Preferred to Be Called	Cell Phone ( )
Home Address	City, State, Zip	Home Phone ( )
Email Address	□ M □ F Social Security Number	Birthdate / /

Primary Insurance Company ______________________ Group ____________ Subscriber ____________

Secondary Insurance Company ______________________ Group ____________ Subscriber ____________

Responsible Party- Person accompanying the child

Name (Mother , Father or Legal Guardian)	Social Security Number	Home/ Cell Phone ( )
Home Address (if different from above)	City, State, Zip	Birthdate / /
Marital Status □ Single □ Married □ Divorced □ Separated	Relationship to Patient	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City State	Zip
Spouse's Name (Mother or Father)	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City State	Zip

Do You (the Patient) Have, or Ever Had? Please Circle

Heart Murmur	YES	NO	Abnormal Blood Pressure	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Abnormal Bleeding	YES	NO	Hepatitis	YES	NO
Heart Condition	YES	NO	Positive HIV Test	YES	NO	Fainting Spells	YES	NO
Malignancy	YES	NO	Radiation Therapy	YES	NO	Anemia	YES	NO
Tuberculosis	YES	NO	Venereal Disease	YES	NO	Might You Be Pregnant?	YES	NO
Rheumatic Fever	YES	NO	Epilepsy/Seizure	YES	NO	Other ____________		

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MEDICAL INFORMATION

Name of your physician______________________ Last physical ______________________

Are you taking any medication?____________ Please list______________________

Are you allergic to any medication/food? ________ Please list ______________________

Have you been hospitalized in the last 5 years?______ Why? ______________________

AGREEMENT TO PAY

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Signature ______________________ **Date** ______________________

Note: There will be a charge of $50 for any missed appointments or appointments not cancelled 24 hours before the appointment time.

FINANCIAL POLICY

Thank you for choosing us for your dental care.
It is our goal to provide you with the finest dental treatment.
This information will explain how we can help you take care of your financial needs.

Payment Options: Cash ATM/ Debit Visa/Master Care Credit

We collect your estimated portion prior to treatment. Please note we check eligibilities and benefits as a courtesy for our patients. Your co-pay at the time of treatment is only an **estimate.** It is the **patients' responsibilities** to know their benefits. Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. As a courtesy, we will bill your insurance company for covered charges. We expect insurance payment within 45 days from the date of service. If your insurance has not paid and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time.

I understand that regardless of any dental insurance coverage I may have I am responsible for payment of dental fees. I agree to pay attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

If there is no insurance coverage available, I understand that I am responsible for all charges incurred, at the time of service. I understand that regardless of insurance, as a person filling out this form I am the responsible party for all charges incur.

I understand that there is a $50 charge for any missed appointments or appointments not canceled within 24 hours before the appointment time.

By law, we are required to maintain the original patient's record and X-Ray. If the patient wishes to have a copy of the x-ray, there will be a $20 charge for each copy.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature______________________________________Date________________________