Date:______________________________

PATIENT INFORMATION

Name:______________________________ ❒ Male ❒ Female **I prefer to be called**:____________
Mr. Mrs. Ms. Dr. LAST FIRST MI

❒ Single ❒ Married **Birthdate**:_____/_____/_____ **Age**:______ **SS#**:______________________________

Home Address:____
Street City Zip

Home Phone:__________________ **Work Phone**:__________________ **Cell Phone**:__________________

Employer:______________________________ **Occupation**:______________________________

Email Address:__________________________ *Where & when are the best times to reach you?*______________

Name & Address of School if a Full Time Student:____

Spouse Name:______________________________ **Birthdate**:_____/_____/_____ **Cell Phone**:____________

Employer:____ **Work Phone**:____________________

*Whom may we thank for referring you?*______________________ *Other family members seen by us*:____________

PERSON RESPONSIBLE FOR ACCOUNT

Name:____ **Relation**:______________________

Home Phone:______________________ **Cell Phone**:______________________ **Birthdate**:_____/_____/_____

Billing Address:____ **SS#**:____________________
Street City Zip

Employer:____ **Work Phone**:____________________

In the event of an emergency, whom should we contact?

Name:____________________________ **Relation**:________________ **Daytime Phone**:________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name:______________________________________ Group/Policy#:______________

Employee Name:________________________________ Relation:____________ Birthdate:_____/_____/_____

SS#/ID#:________________________ Employer:________________________ Work Phone:______________

Secondary Insurance Co. Name:______________________________________ Group/Policy#:______________

Employee Name:________________________________ Relation:____________ Birthdate:_____/_____/_____

SS#/ID#:________________________ Employer:________________________ Work Phone:______________

CONSENT FOR TREATMENT AND OFFICE POLICY ACKNOWLEDGEMENT

TREATMENT CONSENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my/my dependant's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by myself and the doctor, and to employ assistance as required to provide proper care.

I consent to the use of anesthetics, sedatives, and other medication as necessary for my treatment. **I fully understand that using anesthetic agents embodies certain risks**. ________***Initials***

FINANCIAL POLICY ACKNOWLEDGEMENT

I agree to be responsible for payment of all services rendered on my or my dependant's behalf, **regardless of possible insurance coverage**. I understand that **payment is due at the time of service** unless other arrangements have been made in advance. I understand that a **1.5% finance charge (18% APR) may be charged on any balance over 30 days old**. ________***Initials***

I understand that any cost estimate I am given is **only an estimate** and **unforeseen events may cause a change in the cost for my treatment**. ________***Initials***

In the event financial arrangements are not adhered to, I understand the entire account balance will be considered delinquent and will be **due and payable immediately**. I agree to be responsible for any reasonable collection costs or attorney fees incurred in collecting a delinquent account.

I hereby **authorize payment of the dental benefits** otherwise payable to me to be paid directly to the dental provider.

APPOINTMENT POLICY ACKNOWLEDGEMENT

I understand **the appointment time I schedule will be reserved for me** and my prompt arrival will facilitate my treatment being completed in a timely manner. I understand **I am responsible for keeping my scheduled appointment** regardless of any courtesy call or card I may or may not get. ________***Initials***

I understand that **a prior notice of 2 BUSINESS-DAYS is required** to change or cancel an appointment. The office utilizes a 24-hour answering system I may use for after-hours messages. ________***Initials***

I understand I may be charged a **broken-appointment fee of up to 50% of the treatment amount scheduled** for any appointment missed or cancelled without the **above-required** notification. Exceptions in this policy can only be determined on an individual basis. ________***Initials***

Patient Signature____ **Date**____________________

Parent/Responsible Party Signature____________________________________ **Relationship**__________