PATIENT INFORMATION

(This information is necessary for our files and will be CONFIDENTIAL)

Patient's Name ______________________________ **Age**_____ **Birth Date** ______________
Last First

If minor, name of parent/ guardian ______________ Relationship______________ **Social Security Number** _______ _____ _______

Residence Address ______________________________
Street City Zip

Patient is: __ Married __ Single __ Divorced __ Separated __ Widowed __ Minor

Res. Phone ( ) ______________ **Driver's License Number** ______________ exp_______

Cell Phone/ Pager # ( )______________ **E-Mail Address**______________

Employed by ______________________ **Occupation** ______________________

Business address ______________________ **Bus. Phone ( )** ______________
Street City Zip

Name of nearest relative not living with you ______________ **Relationship** ______________

Complete Address ______________________________
Street City Zip Phone #

Referring Dentist ______________________________
Street City Zip Phone #

COMPLETE FINANCIAL INFORMATION REQUIRED

Person responsible for account ______________ **Relationship**______________ **Social Security Number**______________

Address ______________________________
Street City Zip Phone #

PREFERANCE of PAYMENT ____Cash ____Check ____Visa ____MasterCard

***N*ame of *I*nsurance *C*ompany (primary insurance)** ______________________________

____
Insured Person's Name Birth date Relationship **Social Security No**

____
Name of Group Dental Plan Group No Plan No Name of Union Local

***N*ame of *I*nsurance *C*ompany (secondary insurance)** ______________________________

____
Insured Person's Name Birthdate Relationship **Social Security No**

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Name of Group Dental Plan Group No Plan No Name of Union Local

TERMS AND 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 cost 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 at the time services are performed. **I understand that dental services furnished to me are charges directly to me and that I am personally responsible for payment of all dental services.** If I carry insurance, this office will prepare my insurance forms to assist in making collection from insurance companies and will credit such collection to my account.

Please note that this dental office does not render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½ %per month (18 % per annual) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principle balance on all accounts not paid within 30 days of treatment.

I understand that the fee estimated listed for this dental treatment can only be extended for 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 Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended, I future 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 future term or condition I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

_____**I grant my permission to you, or your assigns, 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 agree to their content.**

Initials

Signed: ______________________________ **Date**______________