

PATIENT INFORMATION

THE INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

PATIENT'S NAME _____ BIRTHDATE _____

RESIDENCE ADDRESS _____ PHONE () _____ CELL _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

MARRIED _____ SINGLE _____ DIVORCED _____ SEPARATED _____

DRIVER'S LICENSE NO. _____ SOCIAL SECURITY NO. _____ / _____ / _____

EMPLOYED BY _____ NO. OF YEARS _____

OCCUPATION _____

BUSINESS ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY NO. _____ / _____ / _____

EMPLOYED BY _____ NO. OF YEARS _____

OCCUPATION _____

BUSINESS ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

NAME OF PHYSICIAN _____ PHONE () _____

FORMER DENTIST _____ PHONE () _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP _____

ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

CONSENT FOR TREATMENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

SIGNED _____ DATE _____

OVER

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY _____ GROUP NO. OR LOCAL _____

ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

INSURED PERSON'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ / _____ / _____ EMPLOYEE NO. _____

SECONDARY INSURANCE COMPANY _____ GROUP NO. OR LOCAL _____

ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

INSURED PERSON'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ / _____ / _____ EMPLOYEE NO. _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL OR COLLEGE _____

INSURANCE AUTHORIZATION

I authorize release of information to all my insurance carriers. I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

SIGNED _____ DATE _____

FINANCIAL POLICY

Our financial policy is payment is due at the time of treatment. We will inform you of the fee of your recommended treatment at the time it is diagnosed. And offer financing options.

We believe these options will prove to be a service to you and your family.

- A 5% reduction in your fee if you pay for services in advance of the treatment being initiated.
- Payment by appointment. This option allows you to spread out the payments according to your treatment plan.
- Payment with Mastercard, Visa, Discover and American Express. This will allow you to comfortably budget your monthly payments.
- Insurance on assignment. As a service to you, we will continue to file your insurance and accept assignment of benefit from your insurance company. This will help reduce your immediate 'out of pocket' expenditures – only the estimated private pay monies will be due at the time of treatment.
- Long term or extended financing will be offered through Care Credit. This is our new financial partner that will allow our patients to invest in their oral health with small monthly payments over an extended period of time.
- A finance charge of 18% may be added to outstanding balances.

I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered.

Signed _____ Date _____

