

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart # _____
(For Office Use Only)

Patient Name: _____
Last First M

Preferred Name: _____

Title: _____
Mr/Ms/Mrs/etc

Gender: Male Female

Family Status: Married Single Child Other

Birth Date: _____

SSN: _____ - _____ - _____

Prev. Visit: _____

Email: _____

Best Time to Call: _____

Phone: _____
Home Mobile
Work Other

Address: _____
Address 1
_____ Address 2
_____ City State Zip

Preferred Appointment Times:

Mon Tues Wed Thurs Fri Sat
 Morning Afternoon Evening Any time

Who may we thank for referring you to our practice?

Dental Office Yellow Pages Internet Newspaper School Work
 Other: _____

Spouse or Responsible Party Information

The following is for: The Patient's Spouse The Person Responsible for Payment
 Both Neither/Not Applicable

Name: _____
Last First M

Preferred Name: _____

Title: _____ Gender: Male Female
Mr/Ms/Mrs/etc

Family Status: Married Single Child Other

Birth Date: _____

SSN: _____ - _____ - _____

Email: _____

Best Time to Call: _____

Phone: _____
Home Mobile
Work Other

Address: _____
Address 1
_____ Address 2
_____ City State Zip

Employment Information

The following is for: The Patient's Spouse The Person Responsible for Payment
 Both Neither/Not Applicable

Employer Name: _____

Phone: _____

Employer Address: _____
Address 1
_____ Address 2
_____ City State Zip

Primary Insurance Information

Primary Dental Insurance

Name of Insured: _____
Last First M

Insured's Birth Date: _____

Group #: _____ ID #: _____

Insured's Address: _____
Address 1

_____ Address 2

_____ City State Zip

Insured's Employer Name: _____

Phone: _____

Employer Address: _____
Address 1

_____ Address 2

_____ City State Zip

Patient's Relationship to Insured: Self Spouse Child Other

Insurance Plan Name: _____

Phone: _____

Insurance Address: _____
Address 1

_____ Address 2

_____ City State Zip

Secondary Insurance Information

Secondary Dental Insurance

Name of Insured: _____
Last First M

Insured's Birth Date: _____

Group #: _____ ID #: _____

Insured's Address: _____
Address 1

Address 2

City State Zip

Insured's Employer Name: _____

Phone: _____

Employer Address: _____
Address 1

Address 2

City State Zip

Patient's Relationship to Insured: Self Spouse Child Other

Insurance Plan Name: _____

Phone: _____

Insurance Address: _____
Address 1

Address 2

City State Zip

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party)

Signature: _____

Date: _____

Relationship to Patient: _____