Patient Information

Patient Name____ Age________ **Birthday**________________
Last **First** **Middle** ☐ **Male** ☐ **Female**
If patient is a minor, give name of parent or legal guardian______________________________ **Relationship** __________

Residence Address____**City**____________________**Zip**____________

Home Phone________________________**Business Phone**__________________________**Cell Phone**____________________

Email ____ **Employed by** ________________________________

Business Address____ **How long?**____________

Driver's License______________________ **State Issued**_________ **Social Security Number**____________________________

Patient is: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Minor**

Emergency Contact Name____**Phone Number**__________________________

Name of Physician ______________________________________**Phone Number**___________________________________

Former Dentist____**Phone Number**_________________________________

Reason for changing dentist?____

Purpose of Appointment ____

Whom may we thank for referring you? ____

Terms & 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 arrangements, must be paid for in cash at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 ½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.
I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patients 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 rendered, or within five (5) days of billing if credit shall be extended. I further 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 further 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 and/or collection fees.
I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters relation to this form.
I have read the above conditions or treatment and agree to their consent:

Signed____**Date**________________