

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name	Social Security Number		Home Phone
Home Address	City, State, Zip		Cell Phone
Email Address			Work Phone
Marital Status □ Single □ Divorced □		MALE	Birthdate
☐ Married ☐ Separ	rated	FEMALE	
Primary Insurance CompanyGroup #		Subscriber	Subscriber D.O.B
Secondary Insurance CompanyGroup #		Subscriber	Subscriber D.O.B
Responsible Party			
Name		Social Security Number	Home Phone
Home Address		City, State, Zip	Birthdate / /
Martial Status □ Single □ Divorced □ Married □ Separated		Relationship to Patient	
Responsible Person's Employer/ Address		Work Phone	
In Case of an Emergency Contact:		Phone ()	Work Phone
How did you hear about our Office? Google Google Tacebook On-line (directory or advertisement) Insurance Plan Health Fair/Community Event Other TV/Radio Ad Newspaper/Magazine ad Drive by/Signage Website If you were referred, whom may we thank for referring you?			
*I will answer all health questions to the best of my knowledge.			
(Initial) After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.			
*Signature	Date	Relationship to Patie	ent
Terms and Conditions This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for 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. 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 release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I 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 the conditions and agree to their content.			
SignedDate			
There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.			