Patient Information

Date:_____
Patient Name: _____ Date of Birth: _____
Nickname:_____
Address:_____
City: _____ State: _____Zip code: _____
Home Phone:_____ Work Phone:_____
Cell Phone: _____
E-mail :_____ SS#:_____ Sex: M or F
Employer:_____ Occupation:_____
Whom may we thank for referring you to our office?_____
IF A MINOR, parents names:_____
School:_____ Grade:_____
IF MARRIED: Spouse's name:_____
Birthday:_____ SS#_____
Employer:_____ Occupation:_____
Work Phone:_____

EMERGENCY INFORMATION

Name of the nearest relative/friend not living with you:_____
Address:_____
Phone #:_____

Financial Agreement

- Dental services provided by our office are an agreement between the patient and the doctor.
- Patients who do not have insurance are required to pay at the time of service.
- The insurance relationship constitutes an agreement between the insurance company and the patient. **Patient is responsible for understanding the terms and limits of his/her benefits**.
- The parent who requests treatment for the child is responsible for all fees for services rendered.
- I understand that where appropriate, credit bureau reports may be obtained.
- I also understand that a finance charge of 1.5% will be assessed for accounts over 60 days.
- Delinquency- In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 35% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

Signature: _____

Treatment
I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of Patient)_____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Signature:_____

INSURANCE INFORMATION

Date:_____

PRIMARY:
Insured's name:_____ Insured's SS#:_____
Insured's birthday:_____ Insured's employer:_____
Insurance company:_____ Insurance telephone #:_____
Address of insurance company:_____
Group/Plan#:_____ Is insurance for: Yourself Spouse Dependent
Benefits: Max_____ Ded_____ Month/Month_____
Prev_____ Basic_____ Major_____
SECONDARY: YES NO
Insured's name:_____ Insured's SS#:_____
Insured's birthday:_____ Insured's employer:_____
Insurance company:_____ Insurance telephone #:_____
Address of insurance company:_____
Group/Plan #:_____ Is insurance for: Yourself Spouse Dependent
Benefits: Max_____ Ded_____ Month/Month_____
Prev_____ Basic_____ Major_____

Patient is responsible for understanding the terms and limits of his/her insurance benefits.

INSURANCE SIGNATURE ON FILE
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.
Authorized signature of covered person/employee:_____

In the event I request my records to be transferred to another dental provider, I authorize the release of my records in advance.

Signature: _____

UPDATE

Initials Date Comments or Changes

_____
_____
_____
_____