Patient Information

Date:____________
Patient Name: _____________________________________ Date of Birth: _______________
Nickname:____________________________________ Sex: M or F
Address:____
City: ______________________________ State: ___________Zip code: ___________________
Home Phone:______________________________ Work Phone:___________________________
Cell Phone: _______________________________
Email :____ SS#:__________________________
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#_______________________________

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.
- Patient portion is due at the time of your appointment. For services that require multiple visits, payment is due at the first visit.
- 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

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:_______________________________________

RECORDS RELEASE

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

Signature: ____

CONSENT FOR CONTACT

Dr. Lesch or his designated staff member may contact me by phone, text or email with reminders to schedule an appointment for any treatment not completed or to schedule a hygiene visit.

Signature: ____

James F Lesch, DDS PO Box 310 Lakeville, MN 55044 (952) 469-5213