PATIENT INFORMATION

THE INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

PATIENT'S NAME_____BIRTHDATE_____

RESIDENCE ADDRESS_____PHONE ( )_____CELL _____

CITY_____STATE_____ZIP_____E-MAIL_____I

MARRIED_____SINGLE_____DIVORCED_____SEPARATED_____

DRIVER'S LICENSE NO._____SOCIAL SECURITY NO._____/_____/_____

EMPLOYED BY_____NO. OF YEARS _____

OCCUPATION_____

BUSINESS ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

SPOUSE OR PARENT'S NAME_____BIRTHDATE_____

ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____ SOCIAL SECURITY NO._____/_____/_____

EMPLOYED BY_____NO. OF YEARS_____

OCCUPATION_____

BUSINESS ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____

COMPLETE ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

NAME OF PHYSICIAN_____PHONE ( )_____

FORMER DENTIST_____PHONE ( )_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP _____

ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

CONSENT FOR TREATMENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

SIGNED_____DATE_____

OVER

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY_____GROUP NO.OR LOCAL_____

ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

INSURED PERSON'S NAME_____DATE OF BIRTH_____

SOCIAL SECURITY NUMBER_____/_____/_____ EMPLOYEE NO._____

SECONDARY INSURANCE COMPANY_____GROUP NO. OR LOCAL_____

ADDRESS_____PHONE ( )_____

CITY_____STATE_____ZIP_____

INSURED PERSON'S NAME_____DATE OF BIRTH_____

SOCIAL SECURITY NUMBER_____/_____/_____ EMPLOYEE NO._____

IF PATIENT IS A STUDENT, NAME OF SCHOOL OR COLLEGE_____

INSURANCE AUTHORIZATION

I authorize release of information to all my insurance carriers. I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

SIGNED _____DATE_____

FINANCIAL POLICY

Our financial policy is payment is due at the time of treatment. We will inform you of the fee of your recommended treatment at the time it is diagnosed. And offer financing options.

We believe these options will prove to be a service to you and your family.

- A 5% reduction in your fee if you pay for services in advance of the treatment being initiated.
- Payment by appointment. This option allows you to spread out the payments according to your treatment plan.
- Payment with Mastercard, Visa, Discover and American Express. This will allow you to comfortably budget your monthly payments.
- Insurance on assignment. As a service to you, we will continue to file your insurance and accept assignment of benefit from your insurance company. This will help reduce your immediate 'out of pocket' expenditures – only the estimated private pay monies will be due at the time of treatment.
- Long term or extended financing will be offered through Care Credit. This is our new financial partner that will allow our patients to invest in their oral health with small monthly payments over an extended period of time.
- A finance charge of 18% may be added to outstanding balances.

I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered.

Signed_____ Date _____