PATIENT INFORMATION

DATE: ______________

Name ______________________________ ❑ Married ❑ Single ❑ Minor
Last First M.I.

Address ______________________________
Street Apt. # City State Zip

Home Phone ( ) __________ Birth Date: __________ Social Security # __________

Cell/Pager/Fax ( ) __________ E-mail __________ Work Phone ( ) __________

Occupation: __________ Employer __________

Employer's Address ______________________________

Spouse __________ Employer __________ Work Phone ( ) __________

Who may we thank for referring you? ______________________________

DENTAL INSURANCE

DENTAL INSURANCE COMPANY__________ PHONE # __________ GROUP #__________

INSURANCE BILLING ADDRESS: ______________________________

POLICY HOLDER NAME __________ SS# __________ BIRTH DATE__________

EMPLOYER ______________________________ WORK ( ) __________

ADDRESS ______________________________

Name of Relative, not living with you, to contact in case of emergency ______________________________

Address ______________________________ Home Phone ( ) __________

FINANCIAL OPTIONS

Your payment will be due the date services are rendered, and for your convenience our office does accept cash, checks, Debit Cards, MasterCard, Visa, American Express and Discover. For your convenience we may also hold a credit card on file for automatic preauthorization charges. We also offer Planned Payment Plan (through outside vendors) which, with approved credit, may offer you an instant line of credit.

DENTAL INSURANCE

Patients should realize that professional services are rendered to a person and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We cannot render services on the assumption that the charges will be paid for by the insurance company. However, we will help in every legal way that we can in assisting you and providing you with the appropriate information you need to process your own claims with your insurance company.

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is 18%, applied annually to the last month's balance. In case of default of payment, I promise to pay any legal interest due on the balance, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that the photographs, slides, and/or videos will be used as a record or my care, and may be used for educational purposes in lectures, demonstrations, and professional publications. I further understand that if the photographs, slides, and/or videos are used in any publication, or as a part of demonstration, reasonable attempts will be made to conceal my identity. No charge will be made for rescheduling an appointment provided that 48 hours notice is given. Otherwise a minimum of $60.00 per half-hour missed appointment will be incurred.

Signature: X ______________________________ Date: __________ DL # __________