



Please Print

Patient's Name			Last	First	Middle	Date of Birth	Sex	SSN			
Patient's Address						Street	Apt #	City	State	Zip	Home Phone
Marital Status		Patient's Employer					Occupation				
M / S / D / W											
Work Address			Street	City	State	Zip	Work Phone				
Email Address						Cell Phone					
Spouse's name			Last	First	Middle	Spouse's Employer			Occupation		
Work Address			Street	City	State	Zip	Work phone				
Emergency person we can contact (other than your family home)											
Name			Work Phone			Home Phone					
Who can we thank for referring you to our office? If not an individual, how did you hear about our office?											

INSURANCE AND FINANCIAL INFORMATION

Primary Insurance Coverage		Insurance Company Name		Insurance Address			
Yes No							
Subscriber's Name		Patient's Relationship to Subscriber		Subscriber's Date of Birth		SSN	
		Self Spouse Dependent					
Group/Program Number		Employer-If different from above			Employer's Address		
Secondary Coverage		Insurance Company Name		Insurance Address			
Yes No							
Subscriber's Name		Patient's Relationship to Subscriber		Subscriber's Date of Birth		SSN	
		Self Spouse Dependent					
Group/Program Number		Employer-If different from above			Employer's Address		

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred from their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions of which the office may not be aware. The office staff will estimate insurance coverage to the best of their abilities but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 21 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training. I agree to have clinical photographs taken of me before, during and after treatment for the purpose of scientific training, papers, demonstrations or patient education.

I have read the above conditions of treatment and payment and agree to their content. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE _____ DATE _____ RELATIONSHIP TO PATIENT _____