To Help Us Meet Your Dental Needs Please Complete This Form. Please Ask If You Have Any Questions Or Need Assistance.

PATIENT INFORMATION

Full Name ______________________________ Birthdate ______________

( ) Child ( ) Unmarried ( ) Married ( ) Widowed

Home phone ____________ Work phone ____________ Mobile phone ____________

E-mail: ______________

Mailing address ______________________ City/State ____________ Zip ____________

Patient or Parent's Employer ______________________ SS # ______________

Spouse or Parent's Name ______________________ Work phone ______________

Spouse or Parent's Employer ______________________ SS # ______________

How did you hear about our office? ______________________________

Person to contact in case of an emergency ______________________ Phone ______________

RESPONSIBLE PARTY

Name of person responsible for this patient ______________________________

Relationship to patient ______________________________

Home phone ____________ Work phone ____________ Mobile phone ____________

E-mail: ______________

Mailing address ______________________ City/State ____________ Zip ____________

Employer ______________________________ ID # ______________

PLEASE READ THE FOLLOWING INFORMATION AND SIGN:

IN ORDER TO PROVIDE YOU WITH THE HIGHEST QUALITY DENTAL CARE ON A SOUND BUSINESS BASIS, WE PROVIDE OUR PATIENTS WITH AN **ESTIMATE** OF FEES. BY ESTABLISHING A CLEARLY DEFINED METHOD OF PAYMENT, WE HOPE TO ELIMINATE ANY CONFUSION. PAYMENT IS DUE IN FULL AT EACH APPOINTMENT. FOR YOUR CONVENIENCE WE OFFER THE FOLLOWING METHODS OF PAYMENT: CASH, CHECK, CREDIT CARD, OR EXTENDED PAYMENTS WITH CREDIT APPROVAL.

ANY BALANCE OVER 60 DAYS PAST DUE WILL BE SUBJECT TO A 1-1/2% PER MONTH (18% PER ANNUM) FINANCE CHARGE.

FOR OUR PATIENTS WITH DENTAL INSURANCE, OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT TO YOUR INSURANCE COMPANY. THEREFORE, YOU ARE DIRECTLY RESPONSIBLE TO US FOR THE OBLIGATION OF PAYMENT FOR TREATMENT. **YOU WILL BE BILLED FOR ANY INSURANCE CLAIMS NOT PAID WITHIN 60 DAYS OF SERVICE.** WE WILL DO OUR BEST TO HELP YOU MAXIMIZE YOUR INSURANCE BENEFITS.

WE RESPECT YOUR VALUABLE TIME. THEREFORE, WE WILL MAKE THE GREATEST EFFORT TO SEE YOU ON TIME. PLEASE BE PROMPT TO ALL OF YOUR APPOINTMENTS.

PLEASE ADVISE OUR OFFICE AS SOON AS POSSIBLE IF ANY OF THE ABOVE INFORMATION CHANGES IN THE FUTURE.

SIGNATURE ______________________________ DATE ______________

Relationship to patient ______________________

FOR OUR PATIENTS WITH INSURANCE, PLEASE COMPLETE THE BACK OF THIS PAGE