



PATIENT INFORMATION

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  Female  Male  
 Birthday: \_\_\_\_\_  Single  Married  Child  Other  
 Street Address: \_\_\_\_\_ Apt. Number \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work or Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_  
 Do you have dental insurance?  Yes  No

INSURANCE INFORMATION

Name of Primary Insurance Company: \_\_\_\_\_  
 Address of Insurance: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insurance Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Policy Holder's Birthday: \_\_\_\_\_  
 Policy Holder's Social Security Number: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_  
 Patient's relationship to insured:  Self  Spouse  Child  Other

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company: \_\_\_\_\_  
 Address of Insurance: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insurance Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Policy Holder's Birthday: \_\_\_\_\_  
 Policy Holder's Social Security Number: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_  
 Patient's relationship to insured:  Self  Spouse  Child  Other

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 costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed. 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 the payment of 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. A service charge of 1-1/2 % per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for the period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, 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 with 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, 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 matter related to this form. I have read the above conditions of treatment and payment and agree to their content:

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
 Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

