		Patien	t Information				
Patient Name:			[_ Date:			
Last □ Male □ Female Social Security #:		First	MI ☐ Married ☐ Single ☐ Child ☐ Other Birth Date:				
Phone (Home):		(Cell):	(V	Vork):			
Email Address: #			_ Drivers Licence				
Address:Street / Apai			State	Zip Code			
Street Apar	uncin #	Oity	Giate	zip dduc			
		Healtl	h Information				
Date of Last Dental Vis	sit:	Re	eason for this visit:				
Have you ever had any	of the following? F	Please chec	ck those that apply:				
☐ Epilepsy ☐ Kidney Disease ☐ Anemia ☐ Arthritis ☐ Artificial Joints ☐ Asthma ☐ Blood Disease ☐ Cancer ☐ Diabetes	☐ Excessive B☐ Fainting☐ Glaucoma☐ Growths☐ Hay Fever☐ Head Injurie☐ Heart Disea☐ Heart Murm☐ Hepatitis☐ High Blood □	s s se ur		☐ Stroke ☐ Tuberculosis ☐ Tumors ☐ Ulcers ☐ Venereal Disease ☐ Stomach Problems ☐ Sinus Problems ☐ Jaundice ☐ Dizziness			
If yes, please list: • Please LIST ALL MEDI			ovided (Please use additional բ	paper if needed)			
 Have you ever had any If yes, please explain: 	-	-	reatment? □ Yes □ No				
	d to a hospital or nee	ded emerg	ency care during the past two ye	ears?			
			Phone:				
 Are you now under the care of a physician for a specific medical condition? ☐ Yes ☐ No If yes, please explain: 							
 Do you have any health If yes, please explain: 			ification? ☐ Yes ☐ No				
			rs and information provided are t ext appointment without fail.	true and correct. If I ever have			
Signature of patient, parent o	r quardian		Date:				
In Case of Emergency Pl			Phone:				
		Doform	al Information	1			
Whom may we thank for	referring you to our						
☐ Another patient, friend	☐ Another patient.	relative	Dental Office ☐ Yellow Pages	☐ School ☐ Work ☐ Other			

	Responsible Pa	arty Informatio	on		
Please complete the following if you are NOT th	ne Responsible Party:				
Name:					
Name: ☐ Male ☐ Female		☐ Spouse 【	☐ Child ☐ Other		
Social Security #:					
Phone (Home): Address: □ same as patient	(Cell):	(Work):		
Address. 🗖 same as patient					
Street	Ci	ity	State	Zip	
	Employment Info	rmation for Pa	atient		
Employer Name:					
Employer Address:					
			Obsta	7	
Street		City	State	Zip	
	Insurance	Information			
<u>Primary</u> Policy Holder's Name:			Is policy holde	era patient? □Yes □	
No			10 policy moral		
Policy Holder's Birth Date:	First ID #:	MI	Group	#: <u> </u>	
Policy Holder's Address:					
Policy Holder's Place of Employment:	If same as above che	ck here 🗆	State	Zip Code	
Employer Address:					
Patient's relationship to Policy Holder:	☐ Self ☐ Spouse [☐ Child ☐ Other_	State	Zip Code	
Insurance Plan Name and Address:					
<u>Secondary</u> Policy Holder's Name: No			Is policy holde	er a patient? □ Yes □	
Policy Holder's Birth Date:	First ID #:	MI	Group	Group #:	
Street Policy Holder's Place of Employment: _		City	State	Zip Code	
Employer Address:			State	Zip Code	

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 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 for 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 payment of all dental services. This office will help prepare the patients 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 11/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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 have read the above conditions of treatment and payment and agree to their content.							
Signature of patient, parent or		Date:	Relationship to Patient:				
Signature of guarantor of payr		Date:	Relationship to Patient:				