**Welcome!** Thank you for selecting our dental team! We strive to provide the best possible dental care. To help us meet your dental needs, please fill out this form completely in ink. If you need any assistance, please ask us-we will be happy to help!

**PATIENT INFORMATION (Confidential)** Date: ____________

Patient's Name: ____________ SSN: ____________ Birthday: ____________ Age: ______

Address: ____________ City/State/Zip: ____________

Home Phone #: ____________ Cell #: ____________ Sex: M F Marital Status: M S W D

Employer: ____________ Phone #: ____________ Occupation: ____________

Spouse: ____________ SSN: ____________ Occupation: ____________

Employer: ____________ Phone #: ____________

Emergency Contact Person: ____________ Relationship: ____________

Address: ____________ Phone #: ____________

Whom may we thank for referring you to us? ____________

**PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT (Not Applicable If same As Above)**

Name of Responsible Person: ____________ Relationship: ____________

Residence Address: ____________ City/State/Zip: ____________

Home Phone #: ____________ Date of Birth: ____________ SSN: ____________

Employer: ____________ Work Phone # : ____________

Employer's Address: ____________ City/State/Zip: ____________

**IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW:**

PRIMARY INSURANCE (Please Provide A Copy Of Your Identification Card)

Insured's Name: ____________ SSN: ____________ Date of Birth: ____________

Patient's Relationship to Insured: ____________ Employer: ____________ Phone #: ____________

Insurance Company: ____________ Phone #: ____________

Policy #: ____________ Group #: ____________

Claims Address: ____________

SECONDARY INSURANCE (If Applicable)

Insured's Name: ____________ SSN: ____________ Date of Birth: ____________

Patient's Relationship to Insured: ____________ Employer: ____________ Phone #: ____________

Insurance Company: ____________ Phone #: ____________

Policy #: ____________ Group #: ____________

Claims Address: ____________

**Assignment and Release (Please Circle One)**

1. **CASH** A 5% discount will be given when balance is paid in full at time of service.
2. **CHECK** A $25 fee will be charged on all returned checks.
3. **CREDIT CARDS** We accept all major credit cards.
4. **INSURANCE** We electronically file your claim within 24 hours of treatment. Co-payment and/or deductible are due at time of service. Please understand we cannot as a third party, become involved in prolonged insurance negotiations; this is your responsibility.

**** I agree to pay in full at the time of treatment. However, should any balance remain after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection I agree to pay, with or without suit, all attorney fees, court costs, and a collection fee which will be added to the outstanding balance of my account.

Patient's Signature: ____________ Date: ____________

## OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 rendered.

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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

____________________________________ ____________________

Signature of Patient, parent or guardian Date

Relationship to Patient ____________________________________