WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

Patient Information

Patient Name: _____ Preferred Name: _____ Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # _____ Birth Date: _____

Phone (Home): _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

How did you hear about our office? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # _____ Birth Date: _____

Phone (Home): _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Phone (Work): _____ Ext: _____

Dental Insurance Information

Primary

Insurance Plan Name: _____ Group #: _____

Name of Insured: _____ Is Insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ Social Security # _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Paitent's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Insurance Plan Name: _____ Group #: _____

Name of Insured: _____ Is Insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ Social Security # _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Paitent's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my child's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

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

I understand that the fee estimate listed for this dental care can only be extended for a period of ninety days 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 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 consititute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereafter.

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.

_____ Date: _____ Relationship to patient: _____

Signature of patient, parent or guardian