PATIENT HISTORY AND INFORMATION

Name:_____Birthdate:_____Spouse's Name: _____

Residence Address: _____
Street City Zip Code

If patient is a minor, give parent name: _____

If full time student, give name of school: _____
City

☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed

Driver's Lic. No:_____ SS #:_____ Res. Phone_____Cell Phone:_____

Email Address:_____

Employed By:_____ Bus. Phone: _____

Business Address:_____ Occupation: _____

Spouse Employed By:_____ Bus Phone:_____

Business Address:_____ Occupation: _____

Referred to Us By: _____ Phone: _____

Person to contact for Emergency:_____ Phone:_____

PRIMARY INSURANCE

Insurance Company:_____

Employee: _____

Insured Birthdate: _____

Emp. Social Security:_____

SECONDARY NSURANCE

Insurance Company: _____

Employee: _____

Insured Birthdate: _____

Emp. Social Security: _____

CONSENT:

I herby authorize Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to prescribe any and all forms of medications, and perform any therapy that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment for dental services provided in this office for me or my dependents are **DUE AND PAYABLE** at the time services are rendered. To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged directly to the patients and that patients are responsible for payment of fees.** We do not render services on the basis that insurance companies will pay our fees. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless financial arrangements have been made.** I further understand that a 10% finance charge will be added to any balance over 60 days. If you must change a scheduled appointment, please inform us as soon as possible. **If we are not notified before 3:00 p.m. the working day prior to your appointment, then we may regrettably charge your account.** In the event of default, I (We) promise to pay legal interest on the indebtedness together with such collection cost and reasonable fees as may be required to effect collection of this note.

Disclaimer: "Dentist makes patient no promise, representation or warranty of a particular result or outcome of treatment. No prior written or oral promise, representation or warranty of a particular result or outcome of treatment made by Dentist, his or her employees, agents or staff shall bind Dentist."

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD

Patient or Responsible Party: _____ Date:_____