Patient Information

This information is necessary for our files and will be considered CONFIDENTIAL

Patient's Name_____ _____ ____ Age_____ Patient's Birthday_____ □ Male □ Female
Last First Initial

If patient is a minor, give name of parent or legal guardian_____Relationship_____

Residence Address_____ _____ _____ _____ For how long?_____ □ Own □ Rent
Street City State Zip

Patient is: □ Married □ Single □ Divorced □ Widowed □ Minor E-mail _____

Driver's License No._____ Social Security No._____ Res. Phone _____

Bank_____ Account No. _____ How long? _____

Employed by_____ How long? _____ Occupation _____

Business Address_____ _____ _____ _____ Bus. Phone _____
Street City State Zip

Spouse's Name _____ Driver's License No. _____ Social Security No. _____

Employed by_____ How long? _____ Occupation _____

Business Address _____ _____ _____ _____ Bus. Phone _____
Street City State Zip

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ _____ _____ _____Res. Phone _____
Street City State Zip

Name of Physician_____ _____ _____
Address City Telephone

Former Dentist _____ _____ _____
Address City Telephone

Why are you changing dentists? _____

Purpose of Appointment? _____

Is this office visit for Emergency Dental Care? □ Yes □ No If yes, explain: _____

School children attend _____ Whom may we thank for referring you? _____

Financial Information

Person responsible for this account _____ Relationship_____

Address_____ _____ _____ _____ _____
Street City State Zip Telephone

PREFERENCE OF PAYMENT: □ CASH ON DAY OF TREATMENT

□ VISA/MASTERCARD NO. _____ EXP. DATE _____

□ AMERICN EXPRESS/DISCOVER NO. _____ EXP. DATE _____

Name of insurance company (primary insurance)_____

_____ _____ _____ _____
Insured Person's Name Birth date Relationship Social Security No.

_____ _____ _____ _____ _____
Name of Group Dental Plan Group No. Plan No. Name of Union Local

Name of Insurance Company (secondary insurance) _____

_____ _____ _____ _____
Insured Person's Name Birth Date Relationship Social Security No.

_____ _____ _____ _____ _____
Name of Group Dental Plan Group No. Plan No. Name of Union Local

Terms and Conditions

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help me prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
Assignment of Insurance: I herby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
A service charge of 1½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.
I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.
In consideration of the professional services rendered to me, or at my request by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee at the time said services 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. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed to me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.
I grant my permission to you, or your assigns, 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 agree to their content.

Signed:_____Date_____

Consent for Treatment

I herby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.
All services are rendered and accepted under the terms and conditions listed above:
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed:_____ Date: _____ Relationship to Patient: _____