

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME		SOCIAL SECURITY NUMBER	
Home Address		City, State, Zip	
Cell Phone ()	Home Phone ()	Birthdate / /	
Primary Insurance Company _____		Group # _____	Subscriber _____
Secondary Insurance Company _____		Group # _____	Subscriber _____

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address		City, State, Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Birthdate / /
Responsible Person's Employer	Occupation	Work Phone ()
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
If you were referred, whom may we thank for referring you? _____		

CONSENT

*I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor and/or the state of California dental guidelines.

Signature _____ Date _____ Relationship to Patient _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help 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 hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed _____ Date _____

There will be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.