

Dehnert Dental

PATIENT GENERAL INFORMATION

First Name: Last Name: Middle Initial:

Male Female

Married Single Child Other

Mr. Mrs. Ms. Miss Dr. Other

Date of Birth:

Social Security Number

Age

Home Address

City

State

Zip Code

Mailing Address (if
different from above)

City

State

Zip Code

Home Phone (

Work Phone (

Cell Phone

Pager (

Responsible party if patient is a minor

Relationship

Child lives with: (circle those that apply) Mother Father Stepmother Stepfather Grandparent/s Other

Address for responsible party

Home Phone (

Driver's license #

Person responsible for account:

In case of an emergency, contact: Name:

Phone # ()

Primary care physician: Name:

Phone # ()

Who referred you to us?

INSURANCE INFORMATION

PRIMARY INSURANCE: Name of Insurance

Insurance Phone #

ID#

Group#

Patient relationship to the Insured: Self Spouse Child Other

Insurance address:

Insured SSN:

Name of insured:

Insured's Address:

Employer

Insured D.O.B.

SECONDARY INSURANCE: Name of Insurance:

Insurance Phone #

ID#

Group #

Patient relationship to the insured: Self Spouse Child Other

Insurance Address:

Insured SSN:

Name of Insured:

Insured's Address:

Employer

Insured B.O.B.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that de or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this 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 six months 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 as 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 constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit e instituted hereunder.

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.

Signature of patient, parent or guardian

Date:

Relationship to patient:

Signature of guarantor of payment/responsible party

Date:

Relationship to patient: