Patient Information

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Other_____ □ Male □ Female □ Other_____

First name: _____ Last name: _____ Middle Initial: _____

Preferred Name: _____ □ Married □ Single □ Child □ Partnered □ Other _____

Date of Birth: _____ Age: _____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip Code: _____

Mailing address: _____ City: _____ State: _____ Zip Code: _____
(if different than above)

Home number: _____ Work number: _____

Cell number: _____ Email address: _____

What is your preferred method of contact: □ Phone call □ Text □ Email

Responsible party if patient is a minor: _____ Relationship: _____

Child lives with (check all that apply): □ Mother □ Father □ Stepmother □ Stepfather □ Grandparent(s) □ Other _____

Address for responsible party: _____ Phone #: _____

Person responsible for account: _____ Phone #: _____

Emergency contact: _____ Phone #: _____

Primary care physician: _____ Phone #: _____

How did you hear about our office? _____

Insurance Information

Primary Dental Insurance: _____ Insurance phone #: _____

Policy Holder: _____ DOB: _____

Patient relationship to the policy holder: □ Self □ Spouse □ Child □ Other

ID #: _____ Group #: _____ Employer: _____

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 provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from primary 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 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 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 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 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 all content.

_____	_____	_____
Signature of patient, parent, or guardian	Date	Relationship to patient
_____	_____	_____
Signature of guarantor of payment/Responsible party	Date	Relationship to patient