

Date: \_\_\_\_\_

## GETTING TO KNOW YOU AS OUR PATIENT

<b>Patient Name</b>		Social Security Number	Home Phone (    )
Home Address		City, State, Zip	Cell Phone
Email Address		Work Phone	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Birthdate /      /	Drivers License and State
Primary Insurance Company _____		Group _____	Subscriber _____
Secondary Insurance Company _____		Group _____	Subscriber _____

<b>Responsible Party</b>		
Name	Social Security Number	Home Phone (    )
Home Address	City, State, Zip	Birthdate /      /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone (    )
Business Address	City	State                  Zip

<b>Spouse's Name</b>	Social Security Number	Birthdate /      /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone (    )
Spouse's Business Address	City	State                  Zip

**How did you hear about our Office?**  
*(check only one)*

Who selected this Office?     Self                           Spouse                           Parent                           Employer

Where did you find the Phone Number to this Office? \_\_\_\_\_

Referred by a friend                   Yellow Pages                   Relative                           Insurance Plan                   Welcome Wagon  
 Other \_\_\_\_\_                   TV/Radio Ad                   Newspaper AD                   Direct Mailing                   Sign by Building

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 dictate 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.

\*Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Terms and Conditions**

This office depends upon reimbursement from the patient for the costs incurred in their care. 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 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 release 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 proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, 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 may be a charge for any miss            appointments or appointments not cancell            hours before the appointment time.