PATIENT INFORMATION

Patient's Name (Dr. Mr. Mrs. Ms.)_____ Patient's SS# _____

Parent/Guardian Name (if minor)_____ Date of Birth _____

Address (No P.O. Box please)_____

City_____ State _____ ZIP _____

Home Phone No. _____ Business Phone No. _____ Cell Phone No._____

Email_____

Physician Name_____ Address _____

Who may we thank for referring you? _____

Do you have Dental Insurance? Yes____ No _____ Name of Carrier _____

Employee's Name _____ Employee's Date of Birth _____

Employer's Name & Address _____

Group Number _____ SS# of Subscriber _____

Is patient covered by another Dental Plan? Yes __ No__ If Yes: Carrier's Name, Group No. , S.S.# of Guardian and Employer._____
_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	**I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**
x _____	**x** _____
Signed (insured person) Date	Signed (insured person) Date

If you do not have Dental Insurance, how do you intend to pay for services today?

_____ Cash

_____ Check

_____ Visa/ Mastercard

Our office does not over book. The appointment time is reserved only for you. Therefore, after one failed or broken appointment, a $50.00 fee shall be charged. A 24-hour notice is required for cancellations.

There will be a $30.00 charge for all returned checks.

The office does not extend payment plans. The Patient's balance is due in its entirety upon payment of insurance benefits or at the time services are rendered to uninsured patients.

WE WILL NOT, UNDER ANY CIRCUMSTANCES BILL NEW PATIENTS.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 2% monthly finance charge (24% annually) will be added to any balance over 30 days. In the event of default I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party_____ Date _____
Relationship to Patient _____