PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

ABOUT YOU

Today's Date: _____

Name: Last _____ First _____ Middle Initial ____ I prefer to be called _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Birth Date: ____/____/____ SS #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone #: _____ Work #: _____ Ext: _____ Cell #: _____

Email Address: _____

Employer: _____

Employer's Address: _____

Occupation: _____ How Long Held: _____

Best Time / Place to Reach: _____

Previous / Present Dentist: (please circle) _____ Date of Last Dental Visit: _____

SPOUSE INFORMATION

Name: Last _____ First _____ Middle Initial ____ Birth Date: ____/____/____ SS #: _____

Employer: _____ Work #: _____ Ext.: _____

REFERRAL INFORMATION

Are other family members currently seen in our office? ☐ No ☐ Yes Location: _____ Name of Account Holder: _____

How did you hear about our office? ☐ Family / Friends / Co-Workers Name: _____

☐ Internet website: _____ ☐ Angie's List ☐ Google Places ☐ Mynewsmile ☐ Website Search

☐ Direct Mail Piece ☐ Newspaper Advertisement ☐ Television ☐ Magazine

☐ Insurance Plan Name: _____

☐ Other Explain: _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ Phone _____

PREFERENCE OF PAYMENT

Dental Insurance (Name & Co.) _____

Insurance group No. _____

Soc. Sec. No. of Insured _____

DOB of Insured _____

Credit Cards Accepted:

☐ Visa ☐ Mastercard ☐ American Express

☐ Discover ☐ Care Credit

_____

TERMS AND CONSENT FOR TREATMENT

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.

Patients who carry dental insurance understand that all dental services furnished 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 to assist in making collections from insurance companies and will credit 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.

A service charge of 1 1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, I agree to pay, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I grant my permission to you, or to your assigns, to telephone me at home or at my work to discuss matters related to this form.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer any treatment deemed necessary in the care of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed: _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

Please Complete Both Sides