Patient Information

Patient Name: _____ _____ ____ _____ Date: _____
Last, First, MI (Preferred Name)

Social Security #: _____-_____-_____ Birthdate: _____/_____/_____ Gender: M F

Phone (Home): (____) _____ (Work): (____) _____ Ext: _____ Cell: (____) _____

Preferred appointment times: AM PM Any Time M T W Th

Address: _____ Marital Status: M S D W

_____ E-Mail: _____
City ST Zip

Spouse or Responsible Party Information

The following is for: Spouse Person responsible for payment

Name: _____
Male Female Married Single Child Other

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____

Phone (Home): (_____) _____ (Work): (_____) _____ Ext: _____

Address: _____

_____
City ST Zip

Employment Information

The following is for: Patient Person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ Phone: (_____) _____
Street City/ST Zip

Whom may we thank for your referral? _____

Consent for Services

This practice depends upon reimbursement from the patients for the costs incurred in their care at the time services are rendered. Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept assignment of benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsible for any balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date treatment planned. Should collection procedures become necessary, the patient will be responsible for all collection and legal fees.

Consent for exam and treatment is given and I understand that I have the opportunity to ask for clarification of procedures as they become necessary. I may refuse any treatment understanding it may result in loss of teeth and further complications. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian, guarantor of payment/responsible party.