ASSOCIATES IN DENTAL HEALTH

WELCOME!

Thank you for selecting our office for your care. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form *completely,* both sides. If you need any assistance, please ask. We will be happy to help.

PERSONAL INFORMATION

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (H) _____ (W) _____ (Cell) _____

Email _____

Address: _____
Street Apartment # PO Box

_____
City State Zip Code

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Website ☐ Insurance ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

PARENTAL INFORMATION

The following is for: ☐ the patient's father ☐ the patient's mother ☐ the patient's guardian

Parent/Guardian Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (H) _____ (W) _____ (Cell) _____ Email _____

Address: _____
Street Apartment #

_____
City State Zip Code

The person accompanying the child is responsible for all payments and co-payments at the time of the visit.

FINANCIAL INFORMATION

All emergency dental services, insurance co-payments, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

For your convenience we offer the following methods of payment. Please check the option you prefer:

Cash ☐ Personal Check ☐ Credit Card: MC ☐ Visa ☐ Discover ☐

Please Complete Other Side

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the patient's father ☐ the patient's mother ☐ the patient's guardian

Employer Name: _____ Occupation:_____

Address: _____
Street City State Zip Code

PRIMARY INSURANCE INFORMATION

Name of Subscriber: _____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ Subscriber's Social Security #: _____

Subscriber's Address:_____
Street City State Zip Code

Subscriber's Employer Name:_____

Employer Address:_____
Street City State Zip Code

Insurance Group #: _____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name:_____ Plan Telephone #: ( )_____

Insurance Plan Address:_____
Street City State Zip Code

Do you have a secondary dental insurance? ☐ No ☐ Yes, _____
Insurance Plan Name

Please provide your insurance cards so we may make a copy for your file.

CONSENT FOR SERVICES

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 patients insurance forms or assist in making collections from 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 authorize the dentist to release any information regarding treatment rendered to me or my child to third party payers and/or other health professionals.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within fourteen (14) days of billing if credit shall be extended. I further agree that the reasonable 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 be 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 agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

Thank you for filling out this form completely.