

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Date: _____
Last First MI

Male Female Single Married Divorced Widowed Domestic Partner
Spouse/Partner's name: _____

Social Security Number: _____ Birth Date: _____ E-mail: _____

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

What is your preferred method of contact? Home Phone Work Phone Cell Phone E-Mail

May we leave confidential voicemail messages on any of the above phone numbers?
 No Yes If yes, please specify: Home Work Cell

Address: _____
Street Apartment/Unit Number

City State Zip Code

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Spouse Parent Guardian

Name: _____ Preferred: _____ Date: _____
Last First MI

Male Female Single Married Divorced Widowed Domestic Partner

Social Security Number: _____ Birth Date: _____ E-mail: _____

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

What is your preferred method of contact? Home Phone Work Phone Cell Phone E-Mail

Address: _____
Street Apartment/Unit Number

City State Zip Code

EMPLOYMENT INFORMATION

The following is for: The patient The personal responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Do you have dental insurance benefits? No Yes If yes, please present insurance information at first visit.

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Another patient, friend Another patient, relative Name: _____

Yellow Pages Website Newspaper School Work

Medical Doctor Name: _____ Dental Office Other _____

PLEASE TURN OVER

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BY THE X.

PAYMENT AGREEMENT

- As a condition of treatment by this office, payment is required at the time of service.
- Payment may be made by Cash, Personal Check, MasterCard, Visa, Discover, American Express.
- Financing is available through CareCredit and CapitalOne; please ask for more details.
- Failure to make payments may result in your account being turned over to a collection agency.
You are responsible for reasonable attorney and/or collection fees accrued due to a delinquent account.
- A non-sufficient fund (NSF) fee of \$35 per payment returned.
- A service charge of 1½% per month (18% per annum) is charged on the balance of accounts over 30 days.

I have read the above conditions of treatment and agree to their content.

X _____ Date: _____
Signature of patient, parent, or guardian

APPOINTMENT AGREEMENT

- Appointments scheduled in our office are customized to each individual patient.
- We would like the consideration of at least a 24-hour business day notice to cancel or change appointments.
- A fee of \$100 per hour scheduled will be charged for any failed or cancelled appointments without adequate notice.
- Please keep in mind that we can not accept cancellations by voicemail after business hours.

I have read the above and I agree to the content.

X _____ Date: _____
Signature of patient, parent, or guardian

ACKNOWLEDGEMENT AND CONSENT

- To the best of my knowledge the information provided is accurate, and I understand that it is my responsibility to inform this office of any changes to the information provided.
- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make thorough diagnosis.
- Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read the above and I agree to the content.

X _____ Date: _____
Signature of patient, parent, or guardian