

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F	Drivers License and State
Primary Insurance Company _____ Group _____ Subscriber _____		
Secondary Insurance Company _____ Group _____ Subscriber _____		

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ()
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address	City	State Zip

How did you hear about our Office? (check only one)				
Who selected this Office? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Employer				
Where did you find the Phone Number to this Office? _____				
<input type="checkbox"/> Referred by a friend	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Relative	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Welcome Wagon
<input type="checkbox"/> Other _____	<input type="checkbox"/> TV/Radio Ad	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Direct Mailing	<input type="checkbox"/> Sign by Building
If you were referred, whom may we thank for referring you? _____				

CONSENT		
•I will answer all health questions to the best of my knowledge _____ Initial		
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.		
Signature	Date	Relationship to Patient

TERMS AND CONDITIONS		
This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.		
<p>Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.</p>		
Signed _____	Date _____	
There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.		

