PATIENT INFORMATION

SIDE ONE

Patient's Name (Dr. Mr. Mrs. Ms.) ______________________ Patient's SS# __________

Parent/Guardian Name (if minor) ______________________ Date of Birth __________

Address (No P.O. Box please) ______________________

City ______________ State __________ ZIP __________

Home Phone # ______________ Business Phone # __________ Cell Phone # __________

Physician Name ______________ Address ______________

Who may we thank for referring you? ______________________

Do you have Dental Insurance? Yes _____ No _____ Name of Carrier ______________

Employee's Name ______________ Employee's Date of Birth ______________

Employer's Name & Address ______________________

Group Number ______________ SS# of Subscriber ______________

Is patient covered by another Dental Plan? Yes _____ No _____ If Yes: Carrier's Name, Group No., S.S.# of Guardian and Employer.

____

____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.	I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.
Signed (Insured Person) ______ Date ______	Signed (Insured Person) ______ Date ______

If you do not have Dental Insurance, how do you intend to pay for services today?

_______ Cash

_______ Check

_______ Visa/Mastercard

- **Our office does not over book. The appointment time is reserved only for you. Therefore, after one failed or broken appointment, a $50.00 fee shall be charged. A 24-hour notice is required for cancellations.**
- **There will be a $40.00 charge for all returned checks.**
- **The office does not extend payment plans. The Patient's balance is due in its entirety upon payment of insurance benefits or at the time services are rendered to uninsured patients.**

WE WILL NOT, UNDER ANY CIRCUMSTANCES BILL NEW PATIENTS.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 2% monthly finance charge (24% annually) will be added to any balance over 30 days. In the event of default I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party ______________________ Date __________

Relationship to Patient ______________________

PLEASE COMPLETE SIDE TWO