**Date__________**

# GETTING TO KNOW YOU AS OUR PATIENT

| Patient Name | SSN | Primary Phone |
|---|---|---|
| Home Address | City, State, Zip | Birthdate<br>/ / |
| Marital Status<br>Single Married Divorced | Email Address | Male / Female |

## How did you hear about our office?

(circle only one)

*Who selected this office?* Self Spouse Parent Employer

*Where did you find the phone number to this office?* Referred by friend Yellow Pages Relative Insurance Plan Ad Direct Mailing Sign Other ___________________________

*If you were referred, who 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 judgment 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 is 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 office cannot render services on the assumption that charges will be paid by an insurance company.

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 estimates listed for this dental care can only be extended for a period of 90 days from the day of the 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. 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. In addition to these policies, I acknowledge that there may be a charge for any missed appointments not cancelled at least 48 hours prior to my scheduled appointment time. I have read the above conditions and have agreed to their content.

Signed:_______________________________________________________________Date:______________________