Patient Information

Full Patient Name (First, Middle, Last)	Preferred Name	
Gender ◯ Male ◯ Female	Birth Date	Social Security Number (SSN)
Street Address		
City	State	Zipcode
Marital Status ◯ Single ◯ Married ◯ Married w/Children ◯ Other		

Cell Phone	Home Phone	Work Phone	Email Address
Employer Name			Employer Phone
Date of Last Dental Visit		Date of Last Cleaning	

Name of Insured Person	Insured Date of Birth	Insured Employer Name
Primary Insurance Provider Name	Insurance Plan Name	Insurance ID Number

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Insurance Authorization

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.

I authorize the use of this electronic signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits

I understand that I am financially responsible for all charges, whether or not paid by insurance.

☐ I agree to the above terms

Patient Name	
Patient (or Guardian/Parent) Signature	Date

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All charges are subject to change upon receiving the explanation of benefits from insurance.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the insurance and that he or she is personally responsible for any dental services not paid by their insurance. This office will help prepare the patients insurance forms or assist in making collections from insurances companies and will credit any collections to the patients account, however, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) business days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, with the time payment is due. 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 to discuss this statement or my treatment.

I understand the above information and agree with its contents.

Patient Name	
Patient (or Guardian/Parent) Signature	**Date**

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HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to disclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.

Please write the names of anyone who you authorize to make changes or cancel appointments. This allows us to discuss treatment, financial situations and medical concerns.

Contact #1 : _____

Contact #2 : _____

Contact #3 : _____

Contact #4 : _____

Contact #5 : _____

Patient Name	
Patient (or Guardian/Parent) Signature	**Date**

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