New Patient Information

Patient Name_____ ( )Male ( )Female
Home Phone_____Cell Phone_____
Home Address_____State___ZipCode_____
Date of Birth_____Social Security #_____
( )Single ( )Married Name Of Spouse_____ ( )Children
E-Mail Address_____

In Case of Emergency
Name of nearest relative not living with you_____
Relationship_____Phone#_____Address_____

Whom may we thank for referring you to us_____

Insurance Information
Name of Insurance Plan_____Primary Insured_____
Insured Date of Birth_____Insured Social Security#_____
Group#_____Insurance Address_____

Person responsible for payment of this account
Name of responsible person_____Relationship_____Phone_____
Address_____Social Security#_____
Employer_____Years Employed____Work#_____
Employer's Address_____

Agreement of Financial Responsibilities
In accordance with the federal truth in lending act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to our office. The responsible party agrees to:

1. Payment for all services provided is the responsibility of the patient or guarantor. Your estimated portion will be due at the time of service.
2. That if payments are extended beyond 30 days from the date of first billing to pay 1-1/2% per month on the unpaid balance(annual rate 18%).
3. Should your account be turned over to collections, the undersigned agrees to pay all costs to collect the debt, including, but not limited, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.
4. A $25.00 fee will be charged for any returned checks
5. A $75.00 fee will be charged for missed appointments with less than 24 hour notice

Insurance

We work with most dental insurance companies and will bill them on your behalf as a courtesy. We will verify your benefits although often times, the information we receive is automated, so we encourage you to always understand your specific benefits and policy limitations. Insurance is considered a method of payment only and does not dictate the appropriate treatment. They may allow less than our standard fees, deny necessary treatment and frequently downgrade to a lesser procedure.

By signing below I acknowledge that the above policies have been explained to me, all of my questions have been answered and I agree to abide by them.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Signature Date