Patient Information				
Patient Name: Last First	Middle Initial	(Preferred Name)	Date:	
Gender: Family Status:Married	Single	Child	_Other	
Social Security #:	Birth Date:			
Email Address:				
Please confirm future appointments by Email Text Phone Call				
Phone (Home): (Work):	Ext:	Phone (Cell):		
Address:		VP* 47		
Street	Apartment #			
City	State	· · · · · · · · · · · · · · · · · · ·	Zip Code	
Spouse or Responsible Party Information The following is for: the patient's spouse the person responsible for payment				
Name:				
Last First Middle Initial Gender: Male Female Family Status: Married Single Child Other				
Social Security #: Birth Date:				
Phone (Home): (Work):): (Work): Ext: Best time to call:			
Address: Street Apartment #	Cit.	CA-A-	Zip Code	
Employment Information				
Employer Name:	Occupation:			
INSURANCE INFORMATION		INSURANCE INFO		
PRIMARY Name of Policy	Name of Police	SECONDARY Name of Policy		
Holder	Holder	· · · · · · · · · · · · · · · · · · ·		
Policy Holder Date of Birth	Policy Holder Date of Birth			
ID#Group#Name of Insurance	ID# Group# Name of Insurance			
Plan:	Plan:			
Patients relation to Policy Holder: Self Spouse Child Other	Patients relation to Policy Holder: Self Spouse Child Other			
Consent for Services				
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignce, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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, collection fees and reasonable attorney fees if suit be instituted hereunder. 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 of treatment and payment and agree to their content. Date: Date:				
Signature of patient, parent or guardian	c Kela	nonsnip to Patient:		