Patient Name	**Birthdate** / /	**Cell Phone Number** ( )
Home Address	City, State, Zip	Home Phone Number ( )
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated Sex ❑ M ❑ F	Email Address	Social Security Number
Insurance Company	Group #	Member ID #
How do you feel your overall oral health is? 1 2 3 4 5 6 7 8 9 10 Poor Excellent		
How did you hear about our Office? ❑ Referred by a Friend/Relative _____ ❑ Yellow Pages ❑ Insurance Plan ❑ Direct Mailing ❑ TV/Radio Ad ❑ Walk By ❑ Directory/Magazine ❑ Newspaper Ad ❑ Other _____		
In case of emergency contact Name:	Phone ( )	Relationship to Patient
Responsible Party (If patient is not insurance policy holder or is a minor)		
Name	Birthdate / /	Phone ( )
Home Address	City, State, Zip	Social Security Number
Responsible Person's Employer	Occupation	Relationship to Patient

TERMS AND CONDITION

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be 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 dental 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 estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's 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 you. 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. I have read the above conditions and agree to their content.

Signed_____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.