Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Email: _____ May we confirm appt via Email? __Yes ___No

Address: _____
Street city State zip

Name of emergency contact: _____Relationship _____ phone #s: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

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.

Insurance Statement

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. With healthcare rapidly changing, it would be impossible for us to keep up with thousands of different plans. **The patient is responsible for understanding their own policies.** We will do everything we can to assist with that understanding but you; the patient must ultimately be responsible for understanding your policy. **We are an OUT-OF-NETWORK provider. We do not accept contracted insurance plans. We "do" accept insurance plans that allow the patient the right to choose their own dentist.**

Financial Policy

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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.
Payment for services is expected at the time services are rendered unless prior arrangements have been made. We accept Visa, MasterCard, Discover, checks and cash. We offer a 5% cash discount on balances over $500.00 and we offer payment plans some without interest through outside financial sources. There is a $30.00 charge for returned checks.

Contact Statement

We know how busy you are and we understand your time is valuable. Your satisfaction is our top priority and we try our best to run on schedule and trust you will too. Dr. Davis requires confirmation of your appointment so we know to expect you. In the event you have to cancel, we ask for a 24 hour notice. 48 hour notice of cancelation is required on appointments (4) hours and longer. A charge of $25 or more (depending on length of appointment missed) may be assessed for "**no shows".**

I grant my permission to you or your assignee, to telephone me at home, work or by cell phone to discuss matters related to this form. __Yes __ NO
I grant my permission to you or your assignee to leave messages about my appointments at my home, work, cell phone or Email. __Yes __NO__
I would like to receive newsletters and special information bulletins specific to our office via Email: __Yes __NO

Privacy Statement

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but **only if you agree that we may do so.
I grant my permission to you or your assignee, to provide the following family member (s), friend or other person right of disclosure to my healthcare records including discussion of payment on my account: This agreement will remain in effect indefinitely unless I resend permission.

Name: _____ Relationship: _____
Name: _____ Relationship:_____
Name: _____ Relationship: _____

I have read the above conditions of treatment, privacy and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party