# New Patient Information Record

(Please Print)

Promo Code:

Email Form

## PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address (Home) _____ City _____ State _____ Zip _____ Phone _____

Employer _____ Occupation _____ Social Security # _____

e-mail Address _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Name of Spouse (or Parent, if Minor) _____ Date of Birth _____

Spouse's Employer _____ Occupation _____ Social Security # _____

Whom may we thank for referring you to this office? _____

## RESPONSIBLE PARTY INFORMATION

Name _____ Relationship _____

Date of Birth _____ Age _____ Sex _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address (Home) _____ City _____ State _____ Zip _____ Phone _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Primary Insurance Company _____ Group # _____ Policy # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Secondary Insurance Company _____ Group # _____ Policy # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Driver's License Number _____ State _____ Bank/Branch _____

## IN CASE OF EMERGENCY

Name (Relative not Living with You) _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone _____

## FINANCIAL POLICY / AGREEMENT

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following office financial policy for the use of our patients.

All emergency dental services, or any dental services preformed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, check, MasterCard, VISA, DiscoverCard, American Express and Care Credit.

**As a courtesy, we will be happy to assist you in filing your insurance claim. We will estimate as closely as possible your benefits, and you are asked to pay your deductible/ co-payment when services are rendered. We want you to realize that your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract, and the obligation of full payment is with the responsible party.** _____(initial)

**All major treatment and treatment involving a laboratory procedure (crowns, dentures, ortho appliances, etc.) will require an appropriate down payment.**

**Returned checks and balances over 60 days, will be subject to additional collection fees and interest charges of 1-1/2% per month (18% per annum). Charges may also be made for broken appointments and appointments cancelled without 24 hours notice.** _____(initial)

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within five (5) days of billing If credit shall be extended. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received the opportunity of reading and/or obtaining a copy of this office's privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Patient, Parent or Guardian | Date | Relationship to Patient