

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:  M  F      Family Status:  Married  Single  Divorced  Widowed  Separated

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student Status:  Full Time  Part Time

Name of College: \_\_\_\_\_ Location: \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**Insurance Information**

Name of Insured (if different than Responsible Party): \_\_\_\_\_

Address (if different): \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ Insured's Social Security: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

**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. Also, there will be a \$25.00 fee charged for all returned checks.

Patients who carry dental insurance understand that this office will file insurance as a courtesy to the patients, but that 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 by the Doctor, I agree to pay the reasonable value of services to the Doctor, or his assignee, at the time services are rendered. I further agree that the reasonable value of service shall be billed within the time for payment thereof.

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

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient