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Personal Information and Consent Form

Patients Name: _____
Last First Initial

Nickname_____

Date of Birth_____ Age _____ Sex: _____

How does the patient wish to be addressed? _____

Street address: _____

City_____ State: _____ Zip code_____

Primary Parent's Name: _____

Home phone: _____ Cell Phone: _____ email: _____

Primary Parent employed by: _____

Spouse Employed by: _____

Which parent is responsible for this account? _____

Responsible Parent's Driver License Number: _____

Method of payment: Insurance___ Credit card____ Cash___

Purpose of visit: _____

Other family members in this practice: _____

_____

Whom may we thank for this referral: _____

In case of emergency contact (not living with you): _____

Dental insurance (1st coverage)

Employee Name: _____

Date of birth: _____

SSN or ID number: _____

Employer: _____

Name of dental insurance: _____

Group or policy Number: _____

Address: _____

Phone: _____

Dental insurance (2nd coverage)

Employee Name: _____

Date of birth: _____

SSN or ID number: _____

Employer: _____

Name of dental insurance: _____

Group or policy Number: _____

Address: _____

Phone: _____

Release

I authorize the dentist to perform emergency and/or routine diagnostic procedures and treatment including the use of x-rays as may be necessary for proper dental care.

I authorize release of any information concerning my child's health care, advise and treatment for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my child's health care, advise and treatment to another dentist.

I understand that my dental care carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts.

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

PARENT/LEGAL GUARDIAN'S SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE _____

PATIENT FINANCIAL RESPONSIBILTY

My staff and I are pleased to welcome your child as a new patient. To prevent any misunderstandings regarding payment for your child's treatment, please review and sign the following financial policy.

Before we begin any treatment, other than routine visits, we will provide you a printed summary of the projected treatment along with an estimate of the anticipated fees.

The mouth, gums, and teeth are constantly changing due to the progressive nature of dental disease. The actual costs of dental treatment may differ from the estimate due to out treatment of this progressive dental disease. In the event the actual costs of dental treatment differ from the estimated cost, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

CASH PATIENTS

Payment is due at the time of service unless financial arrangements have been previously made with our office. For your convenience, we gladly accept personal checks and most major credit cards including Mastercard and Visa.

PATIENTS WITH INSURANCE-Please read your policy. Please initial the following

Our office does not determine the benefits. The type of plan chosen by your employer determines them. All plans vary with regard to the amount of coverage allowed. Your particular plan may base it's dollar allowance on a fee schedule, which may not coincide with our current acceptable fees. Deductibles, co-insurance factors and yearly maximums combine to reduce the benefits you ultimately receive. Also , please understand that no plan is a "pay-all". _____

Our professional services are rendered to a patient, not to an insurance company. Therefore, the financial obligation for treatment is between you and this office and not dependent upon insurance coverage. We will do our outmost to see that you receive maximum benefits within the structure of your particular plan.

Please remember that you, the parent(s), are ultimately responsible for payment on the account, NOT your insurance company. **Deductible, co-payment, and fees for service not covered are due at the time treatment is provided. _____**

While we do our best to collect all fees due from your insurance carrier, **fees not paid by the carrier within 60 days are due and payable by the patient. If your account remains unpaid past 90 days, it may be sent to a collection agency for non-payment and/or delinquent matters.** All accounts sent to collections are subjected to a collection agency fee and possible other legal costs in addition to the balance that is owed. _____

For your child's first visit, full cash payment is required at the time services are rendered if your insurance coverage is not provided.

The parent or guardian who accompanies the child is responsible for payment.

FAILED APPOINTMENT

There will be a charge for appointment cancellation if a 48 hour notice is not given. _____

It is our earnest desire that quality dental health care be available to all. Please don't hesitate to talk to us if this financial policy causes you any great inconvenience. We will be happy to discuss alternative financial arrangements with you on an individual basis.

I have read and understand the contents of this agreement. I agree to comply with all policies.

Parent's name: _____ Patient's name: _____

Signature: _____ Date: _____