Patient Information

Patient Name: _____ Date:_____
Last First MI

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

Social Security #: _____ Birth Date: _____ Driver License #_____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐Fri ☐Sat

Address: _____
Street Apartment #

_____
City State Zip Code

E-Mail Address: _____

Employment Information

The following is for the patient

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ TV ____ ☐ Radio_____ ☐ Direct Mail

☐ Insurance ☐ Yellow Pages ☐ Newspaper, (Sac. Bee, etc.) _____ ☐Sacramento Magazine
☐ 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: _____ Driver License #_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for the patients spouse or the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Cancellation Notice

To be able to serve all patients with the same commitment, keep in mind that schedules appointments are extremely precious. If you cannot keep a scheduled appointment a 24hour cancellation notice by you is required. We do realize that certain emergencies are unavoidable.

Missed appointments without a 24hr notice will be charges at the rate of $50 for each hour scheduled. Saturday missed appointments will be charged at the rate of $75 for each scheduled hour. Please remember that other patients may have desired that time

Patient Initials: _____

Dental and Medical Insurance Information

Dental

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: _____

_____

Medical

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/Payment Policy

The undersigned hereby authorizes doctor to order x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and therapy indicated for such treatment. I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment. Following diagnosis I'll be informed on findings and advised of the suggested treatment plan. After mutual agreement on the treatment plan, treatment will be rendered. ___Initials

As a condition of my treatment, financial arrangements must be made in advance. I'll be presented various financial options and given an opportunity to select the plan that best suits my needs. All emergency dental services, or any dental services rendered without previous financial arrangements, must be paid for at the time services are rendered. 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 examination, unless the fees have been changed by my insurance carrier sooner. I understand that all dental services furnished are charged directly to me and I'm personally responsible for payment for such services. This office will help me prepare all insurance forms and assist in making collections from insurance companies, and will credit any such collections to my account. However, this dental office cannot render services on the assumption that all charges will be paid by an insurance company. Should the insurance company decide not to contribute or pay less than the "guesstimate", I, the patient, will be responsible for any difference owed.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, if user arrangements was not made, I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within 30 days after treatment is rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit will be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, on cell phone, or at my work to discuss matters related to this form.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health status or information on these forms, I will inform the doctor at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content. I authorize to use and disclose my medical information for the purposes of Treatment, Payment and Health Care Operations.*

You may review our "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party