Welcome

PATIENT INFORMATION:

NAME: BIRTHDATE: AGE: SEX:

ADDRESS: CITY: STATE: ZIP:

SINGLE MARRIED SEPARATED WIDOWED DIVORCED SSN:

HOME PHONE: CELL PHONE:

EMAIL ADDRESS:

EMPLOYER: OCCUPATION: BUSINESS PHONE:

WHOM MAY WE THANK FOR REFERRING YOU?:

IN CASE OF EMERGENCY, NOTIFY: PHONE:

INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:

RELATIONSHIP TO PATIENT: BIRTHDATE: SSN:

ADDRESS IF DIFFERENT FROM ABOVE: PHONE:

CITY: STATE: ZIP:

INSURANCE COMPANY: PHONE:

GROUP/POLICY #: SUBSCRIBER ID #:

FOR PROFESSIONAL SERVICES PROVIDED:

We can only offer estimated costs for you. The funds necessary to complete any dental treatment that you may have will be an estimate based on information determined from our examination. Should additional problems occur as treatment progresses, alternative treatment/methods may be required. We will discuss any revisions with you before any additional treatment is provided.

Acceptance of Insurance Assignments by this office does not absolve you of full responsibility for the charges, in full, for the treatment rendered. An estimate, provided by this office, is to be considered a guideline until the final insurance payment is received, and your account has been reconciled. **We make no guarantees of the insurance payment estimated.**

FAILURE TO SIGN this contract does not relieve the responsibile party from financial responsibility for any services that will be rendered, as submission to treatment implies consent.

SIGNATURE: DATE:

NOTICE OF PRIVACY ACT *You may refuse to sign this acknowledgement*

I have received a copy of this office's Notice of Privacy Practices

PRINT NAME: SIGNATURE: DATE:

Office use only: Individual refused to sign Communication barriers prohibited obtaining acknowledgement
Emergency situation prevented us from obtaining acknowledgement Other (please specify)