Patient Information: Date: _____

Name _____ Birthdate _____ SSN _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Circle One: ☐ Married ☐ Single ☐ Minor **Circle One:** ☐ Male ☐ Female

Place of Employment: _____ If Student, School Name: _____

Family Information: Please fill in both blocks for minor child. Fill in appropriate block for adult.

Circle One: ☐ Husband or Father ☐

Name	
Street Address	
City, State, Zip	
Home Phone	
Work Phone	
Cell Phone	
Date of Birth	
SSN	
Employer	
Insurance Co.	
Subscriber ID #	
Group #	

Circle One: ☐ Wife or Mother ☐

Name	
Street Address	
City, State, Zip	
Home Phone	
Work Phone	
Cell Phone	
Date of Birth	
SSN	
Employer	
Insurance Co.	
Subscriber ID #	
Group #	

Person to Contact in Case of Emergency

Name	
Street Address	
City, State, Zip	
Phone #	

Has any member of your family ever been treated in our office? Circle One: ☐ Yes or No ☐

Who may we thank for referring you to Dental Solutions?

_____

Authorization:

I hereby authorize payment directly to Dental Solutions of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dental Solutions to administer such medications and perform such diagnostic, photographic, radiographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

_____

Patient Signature or Signature of Responsible Party

Date _____

Method of Payment:

_____ Payment in full at each appointment

_____ I wish to discuss the Dental Office's Financial Policy

Service Charge:

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rage of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

In today's busy world, we are working hard to contact you in the way that is most convenient for you and your family members! Please tell us how you would like to be reached!

I would prefer to be contacted by: (please check one below)

Home Phone _____
Work Phone _____
Cell Phone _____
Email _____ Email Address:_____
Text Message _____

Your contact information will only be used by Dental Solutions.

Our commitment to your dental care…

We are sure that you will enjoy the dentistry accomplished in our office for many years. Because we are confident that our office provides you with the best dental care available, we replace our crowns, bridges, inlays, and onlays for a period of 5 years from the date of service. In addition, fillings will be replaced for a period of 2 years and preventative sealants for 1 year.

Under our commitment, if it becomes necessary to redo, repair, or replace any of these restorations the services with be provided to you at no charge (with exception to decay/cavities).

Your commitment…

For this commitment to remain valid, you must maintain the minimum ongoing care and treatment prescribed by your dental professional. This includes **maintaining continued hygiene care at Dental Solutions** every 3, 4, or 6 months and completing any restorative treatment as recommended.

Patient Name (Print): _____

Patient/Guardian Signature: _____

SUBMIT