PATIENT INFORMATION

PATIENT INFORMATION (*Confidential*)

Patient's Name _____ Date of Birth _____

Mailing Address _____ Home Address _____

City _____ State _____ Zip _____ Own ____ Rent_____

Home Phone _____ Email Address _____ Male _____ Female _____

Patient's Employer _____ Business Phone _____

Business Address _____ Social Security No. _____

Spouse _____ Spouse's Employer _____

Referred By _____

St George Phone Book ___ Dex Phone Book ___ Local Newspaper ___ Dixie Phone Book ___ Other _____

RESPONSIBLE PARTY (*If patient is a minor, the responsible party is the adult that brings patient in and signs the forms.)*

Name _____ Relationship to Patient _____

Date of Birth _____ Male _____ Female _____ Driver's License # _____

Address _____ Own _____ Rent _____

City _____ State _____ Zip _____

Employer _____ Business Phone # _____

How long have you been employed there? _____ Social Security # _____

Marital Status: Minor _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Spouse _____ Date of Birth _____

Whom may we contact in case of emergency? _____ Phone _____

Nearest Relative not living with you? _____ Phone _____

Primary Insurance

Insurance Company _____ Group # _____ S.S. # _____

Insurance Address _____ Phone _____

Policy Holder _____ Employer _____ Birth Date _____

Secondary Insurance

Insurance Company _____ Group # _____ S.S. # _____

Insurance Address _____ Phone _____

Policy Holder _____ Employer _____ Birth Date _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature _____ Date _____

Furthermore, I authorize any release of any information in the relationship to this claim and agree that payment of the dental benefits otherwise payable to me may be sent directly to Staples Dental Care.

Signature _____ Date _____

Staples Dental Care

PERSONALIZED & COMFORTABLE

We are committed to providing you with the best possible care. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs and we assume that you are as concerned as we are about maintaining good dental health.

Payment for services is due at the time services are rendered. Full payment is expected on your initial visit. We accept cash, checks, Master Card, Visa, American Express and Discover. If arrangements need to be made on further work, we want to assist you as much as possible without acting as a financial institution. We have sought the easiest financing available. We are able to offer you six months of interest free financing through a local company. When you qualify, that company pays us at time of service and you can then stretch your payments out comfortably over that period without incurring any further expense. This is far better financing than we could offer you in this office.

Fee estimates listed for dental treatment can only be extended for a period of six months from the date given. Returned checks and balances older than 90 days will be subject to additional collection fees and interest charges of 1 ½% per month.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. However, you must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Insurance benefit assignments will be paid to you. You will be responsible for whatever fees you have incurred through services provided to you by Staples Dental Care.

In consideration for the professional service rendered to me, at my request, by the Doctor, I agree to pay therefore the value of said Doctor, or his assignee, at the time said services are rendered. I further agree to pay all costs of collections including a 50% collection fee, attorney fees and court costs if suit be instituted hereunder. I grant my permission to you or your assignees to telephone me at home or at work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature _____ Date _____