

daniel daniel

D E N T I S T R Y

How did you hear about our office? _____

Name _____
Surname First Middle initial Preferred

Birth date _____
Month day Year

Address _____
Street City Postal code

Home phone _____ Work _____ Cell _____

E-mail _____

Emergency contact _____ Relationship _____

Insurance and Financial Information (optional)

Insurance Information Yes No

Insurance company _____

Subscriber _____ Relation _____ Subscriber's birth date _____

Policy / Plan _____ Certificate / ID _____

Employer _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance form and assist in making collections from insurance companies.

I certify that I have read the contents of this form.

Signature _____ Date _____