Creekside Dental Arts

Please answer the following questions. All information will be kept strictly confidential. Thank you.

Patient's Name _____ Preferred Name _____

❑ Male ❑ Female Social Security Number _____ Birth date _____ /_____ /_____

Mailing Address _____ Home Phone (_____) _____

City _____ State _____ Zip Code _____

Cell _____ Fax _____ Email _____

Patient's Occupation _____ Employer _____ Work Phone (_____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone (_____)_____ Work Phone (_____) _____

Relationship to Patient _____

Insurance Information

Primary

Name of insured _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth date _____ ID Number _____ Group Number _____

Insured's Address _____

Insured's Employer Name _____

Insured's Employer's Address _____

Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name _____ Insurance Plan Address _____

Secondary

Name of insured _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth date _____ ID Number _____ Group Number _____

Insured's Address _____

Insured's Employer Name _____

Insured's Employer's Address _____

Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name _____ Insurance Plan Address _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A service charge of 1% per month (12% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that a fee of $25 per 1/2 hour of scheduled time may be incurred if I fail to show up for a scheduled appointment or cancel without 24-hour notice. I understand that I may be dismissed as a patient of Creekside Dental Arts if I fail to keep scheduled appointments without good reason or on numerous occasions.

I grant my consent for treatment based on the recommendations of my dentist and understand the risks and possible limitations of proposed treatment or my lack of compliance. I will ask my dentist or other staff members to explain all risks and benefits of dental treatment so I can give my informed consent. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Signature of Patient, Parent or Guardian | Date | Relationship to Patient