

# Welcome to Elite Dental Care

*The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.*

## Patient Information

### About You

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Why did you select our office? \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed Spouse's Name \_\_\_\_\_

### Telephone Information

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
When is the best time to call you? \_\_\_\_\_ Where? \_\_\_\_\_  
In case of an emergency, is there someone we can call?  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Financial Information

Person responsible for payment of services: \_\_\_\_\_

#### **Please check the appropriate box(es):**

1. Cash and personal checks are accepted as your treatments are provided.
2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.

This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

3. MasterCard, Visa, American Express, Discover

4. For long term or extended payments, we offer a healthcare financing program which, when you are accepted, will allow small monthly payments for the treatment received.

## Responsible Party Information

Name: \_\_\_\_\_

Male Female

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

## Insurance Information

### **PRIMARY:**

Name of Insured: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

Patient's relationship to the insured: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City State Zip Code: \_\_\_\_\_

### **SECONDARY:**

Name of Insured: \_\_\_\_\_

Insurer's Birth Date: \_\_\_\_\_

Insurer's SSN: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurer's Address \_\_\_\_\_

City State Zip Code: \_\_\_\_\_

Patient's relationship to the insured: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City State Zip Code: \_\_\_\_\_

## 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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services.

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have reviewed a copy of the Dental Material Facts Sheet as required by law.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_