JORDANview DENTAL

PATIENT INFORMATION

NAME_____ DATE _____
Last First Initial

☐ Male ☐ Female ☐Child ☐ Single ☐ Married ☐ Other

SOCIAL SECURITY #: _____ BIRTHDATE _____/_____/_____

TELEPHONE: (Home)_____(Work)_____(Cell)_____

ADDRESS _____
Street Apt. #

_____
City ST Zip

INSURANCE INFORMATION

E-mail:_____☐ Please email me appt. reminders

PRIMARY INSURED/ IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
Last First Initial	Last First Initial
Birthdate Social Security #	Street City ST Zip
Home Address	Home Work Cell
City ST ZIP Home Phone	Birthdate Social Security #
Dental Insurance Co. Phone #	Dental Insurance Co. Phone #
Subscriber # Group #	Subscriber # Group #

Referral Information

Whom may we thank for referring you?_____

AUTHORIZATION

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 or she is personally responsible for payment of all dental services. The 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, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for the 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, 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 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.

X_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

X_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party