

Thank you for choosing our dental office. We know that you will be pleased with the care that you receive and that you'll refer your friends and relatives. Our mission is to provide the highest quality dental care in the most gentle, personal and comprehensive manner possible so that our patients will enjoy healthy, comfortable and aesthetic natural dentition throughout their lives.

PATIENT INFORMATION:

TODAY'S DATE: _____

Name: _____ (Last) _____ (First) _____ (Middle)

I prefer to be addressed as: _____ E-mail: _____

Address: _____

Home phone: _____ Work phone: _____ Date of Birth: _____ Age: _____ Sex: _____

Marital Status: _____ Soc. Sec. #: _____ Driver's License #: _____

Occupation: _____ Cell #: _____

Employer: _____ Years with firm: _____

Employer's Address: _____

SPOUSE INFORMATION:

Spouse's Name: _____ Occupation: _____

Employer: _____ Yrs. with firm: _____

Soc. Sec. #: _____ Work Phone: _____

CHILDREN'S NAMES AND AGES

PLEASE COMPLETE IF PATIENT IS A MINOR:

Parents' or Guardians' Names: _____

Birthdate: _____ Birthdate: _____

Soc. Sec. #: _____ Soc. Sec. #: _____

Driver's License #: _____ Driver's License #: _____

Address: _____ Address: _____

WHO AMONGST YOUR FRIENDS AND RELATIVES MAY WE SEND OUR NEWSLETTER TO:

Name: _____

Address: _____

DENTAL INSURANCE INFORMATION:

Insured's Name: _____

Ins. Co. name and address: _____

Insured's employer: _____

Insured's Soc. Sec. #: _____ Insured's date of birth: _____

How did you hear about our office? _____

APPOINTMENT CANCELLATION POLICY: Appointments cancelled or broken with less than two working days' notice will be subject to a \$63.00 charge per 1/2 hour of scheduled time.

PATIENTS WITH DENTAL INSURANCE: We accept assignment from most insurance companies. Patients are responsible for any deductibles, co-payments and non-covered service at the time service is provided. Any balance remaining unpaid after 45 days from the date of service will be due by the patient. Please consult your benefits handbook or insurance carrier for details.

PATIENTS WITHOUT INSURANCE: Payment is due at the time the service is provided unless other arrangements are made in advance. For extensive treatment, convenient payment plans are available which allow patients to space out payments as desired.

COLLECTION POLICY: We reserve the right to check your credit history when credit is extended. We also reserve the right to report delinquent accounts to the credit bureau. Should collection proceedings be initiated on an account, we shall be entitled to attorney's fees, collection costs and interest on the unpaid balance at an annualized rate of 18%.

PATIENT RECORDS: We are required to retain all original patient records. When provided with a written request, we will provide copies of patient records, including radiographs at the cost of 25% of the original, as provided for by the Maryland State Board of Dental Examiner's.

When patient photographs are taken I hereby authorize their use.

I authorize your office to maintain my signature on file for insurance purposes. I have read and understand the above and all information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____