

fruitland family dental

Patient Information

Patient Name:						
□ Male□	Last Female	First □ Ma r	ried□ Single□ C	мı Child□ C	Other:	
Social Security #: Address:						
Phone (home):	Address			City (v		Zip Code
· , ,			ase don't text m		,	
Email Address:						
The fellowine in few	•	•	onsible Party			Dations.
The following is for Name:		-	•	-	· ·	Patient:
Last Social Security #:	First	MI	Birth Date:			
Phone (home):		(cell):		_ (work)	:	
Address:	Address			City	State	Zip Code
Employer: Address:						Zip Code
,	Address			City	State	
	Address	Inst	urance Infor			
Primary				matio	n	· · · · · · · · · · · · · · · · · · ·
Primary Name of Insured:	Last	First		matio	n Birth	· · · · · · · · · · · · · · · · · · ·
Primary Name of Insured: Relationship to pa	 Last atient: □ Self	First Spouse	□ Child □ Othe	matio	n Birth	Date:
Primary Name of Insured: Relationship to pa Employer: Group#:	Last atient: Self	First Spouse ubscriber ID#	□ Child □ Othe Insur	MI r	n Birth ompany:	Date:
Primary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa	Last atient: Self	First Spouse ubscriber ID#	□ Child □ Othe Insur	MI r	n Birth ompany:	Date:
Primary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa Secondary	Last atient: □ Self Solution Solution Solution Solution Solution Solution	First Spouse ubscriber ID#	□ Child □ Othe Insur	MI r	n Birth	Date:
Primary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa Secondary Name of Insured: Relationship to pa	Last atient: Self Supplement S	First Discriber ID# First Spouse	Child Othe	mation MI rance Co	n Birth ompany:	Date:
Primary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa Secondary Name of Insured: Relationship to pa	Last atient: Self Supplement S	First Ubscriber ID# First Spouse	Child Othe	mation MI rance Co	n Birth company: Birth company:	Date:
Primary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa Secondary Name of Insured: Relationship to pa Employer: Group#: Insurance Compa	Last atient: Self Supplement Supplement Self Last atient: Self Supplement Self	First Ubscriber ID# First Spouse Ubscriber ID#	Child Othe	mation MI r rance Co	n Birth ompany: Birth ompany:	Date:

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

A service charge of 1 ½ % per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

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 of 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 tie or condition hereunder shall not constitutes a waiver of any further term or condition as 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.

	Relationship to Patient:
pt of Notice	of Privacy Practices
ign This Acknov	wledgment*
ivacy Practices	•
	pt of Notice ign This Acknow

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but

☐ Communications barriers prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining acknowledgement

acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Other (Please Specify)