CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

DATE_____

NAME:_____SS#_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE#:_____WORK PHONE#:_____

CELL PHONE#:_____EMAIL:_____

BIRTHDATE_____SEX:_____MARITAL STATUS:_____

YOUR EMPLOYER:_____JOB TITLE:_____

EMPLOYERS ADDRESS:_____

SPOUSE (OR PARENT'S) NAME:_____

SPOUSE (OR PARENT'S) EMPLOYER:_____

EMPLOYERS ADDRESS:_____

HIS/HER WORK#:_____POSITION:_____

WHO REFERRED YOU TO OUR OFFICE:_____

PERSON RESPONSIBLE FOR ACCOUNT

NAME:_____RELATIONSHIP:_____

HIS/HER SS#_____WORK PHONE#:_____

HIS/HER EMPLOYER:_____

HIS/HER ADDRESS:_____

DENTAL INSURANCE

PRIMARY INSURANCE CO:_____

SUBSCRIBER/EMPLOYEE NAME:_____

SECONDARY INSURANCE CO:_____

SUBSCRIBER/EMPLOYEE NAME:_____

I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD PARTY INVOLVEMENT.

SIGNATURE:_____DATE:_____

Which payment method do you prefer for today's services?

☐ Cash ☐ Check ☐ Mastercard ☐ Visa

_____ _____

Signature Date

_____

Parent Signature, if under 18

INSURANCE COVERAGE

It is important that you understand that dental and accident insurance policies are an arrangement between the insurance carrier and you. Any amount authorized to be paid directly to the dentist will be credited to your account on receipt and any over payments will be refunded.

However, you must clearly understand and agree that all services rendered you are charged directly to you and you are personally responsible for payment. Payment for services rendered are due at the time of appointment unless prior arrangements are made with the business office.

In order to facilitate the correct and rapid processing for you insurance claim, we need to have a completed insurance form on file. Please advise us of any insurance changes when applicable.

I hereby authorize payment directly to LINDA ZIMMERMAN, DDS any group dental payments from my insurance company otherwise payable to me, but not to exceed the charges shown. I understand I am financially responsible to said deposit for charges not covered by this agreement.

Signed (Responsible Party)_____

DENTAL INSURANCE

(1) _____ _____

Name of carrier and plan Group/Policy Number

_____

Name of insured

(2) _____ _____

Name of carrier and plan Group/Policy Number

_____

Name of insured

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____