Welcome to Smith & Co. Dental Practitioners

Dr. Smith and staff would like to kindly welcome you into our practice. While taking the time to complete this form, we will be more than happy to assist or answer any questions. We appreciate your commitment to your dental health.

Patient Information

Name____ Social Security # ____________________

Address_______________________________________ City___________ State_______ Zip_________

Home Phone #_________________Cell #________________ E-mail_________________________

Sex ○M ○F Age____ Birthdate_______ ○Married ○Single ○Divorced ○Widowed ○Separated

Employer____Occupation_____________________________________

Business Address_____________________________________ Business Phone #_________________________

Who may we thank for referring you?
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Emergency Contact______________________________________
Home Phone #_____________________________________
Cell Phone #____

Primary Insurance

Person Responsible for Account_____________________________ Relation to Patient _________________________________

Address_______________________________________ City_________________ State______ Zip_______

Employed By _________________Home Phone #__________ Cell Phone #_________ Business Phone #_______________

Insurance Company______________________ Subscriber DOB _________ Group #__________ Subscriber SSN#_________
Names of other dependents under this plan
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Additional Insurance

Person Responsible for Account_____________________________ Relation to Patient _________________________________

Address_______________________________________ City_________________ State______ Zip_______

Employed By _________________Home Phone #__________ Cell Phone #_________ Business Phone #_______________

Insurance Company______________________ Subscriber DOB _________ Group #__________ Subscriber SSN#_________
Names of other dependents under this plan
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Consent for Payment

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 by cash or credit card 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. 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. Any and all benefits from insurance companies and other third party payers that are payable to Patient or on behalf of Patient for dental care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to Dr. Smith for the exclusive purpose of paying for charges associated with dental care services provided to Patient in this office. It is understood and intended that all insurance companies and other third party payers will pay benefits directly to Dr. Smith in payment of Dr. Smith's charges and the charges of any other health care providers for whom Dr. Smith is authorized to bill in connection with health care services provided to Patient.
Patient agrees to be financially responsible for failed, cancelled, or rescheduled appointment fees. These fees range in price from $25 up to, but not in excess of, $125 depending on the nature of treatment for which you were appointed. These fees are not billable to insurance and are thus payable directly by patient. Our office requires a minimum of 48 hours notice prior to a scheduled appointment to exempt you from the failed appointment fees.
A service charge of 1½5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
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 ten (10) days of billing if credit shall be extended. 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. An additional 40% will be added to my account if turned over to a collection agency.
I have read the above conditions of treatment and payment and agree to their content.

Signature ____ Date ______________