Patient Information

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1010 Caughlin Crossing
Reno, Nevada 89519

Patient Name: ______________________ Preferred Name: ______________ Date: __________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Adult ☐ Minor

Social Security #: ______________________ Birth Date: __________

Phone Home # ____________ Work # ____________ Cell # ____________

Home Address ____
Street City Zip

Mailing Address ____
Street City Zip

Referred By ______________________ E-mail ______________________

Person Responsible for Account

Name: ____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ____________

Patient's Employer: ____

Insurance Information

PRIMARY

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ SS # ____________ Group # ____________

Insured's Address ____
Street City Zip

Insured's Employer Name: ____

Employer Address: ____
Street City Zip

Insurance Plan Name: ____

Address: ____
Street City Zip

SECONDARY

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ SS # ____________ Group # ____________

Insured's Address ____
Street City Zip

Insured's Employer Name: ____

Employer Address: ____
Street City Zip

Insurance Plan Name: ____

Address: ____
Street City Zip

Emergency Contact Information

In case of emergency we can contact: ______________________________

Phone Number: ____________ Alternate Number: ____________

Relationship to Patient: ______________________________

Consent For Service

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist and/or dental staff.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

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 cost 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. 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 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 and 1/2 percent per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 6 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 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 breech 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, work or mobile phone to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____________________________ Date: __________ Relationship to Patient ______________

Signature of Patient, Parent or Guardian

____________________________ Date: __________ Relationship to Patient ______________

Signature of guarantor of payment/responsible party

Payment is due in full at time of treatment, unless prior arrangements have been approved.