

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: Married Single Child
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ E-Mail: _____
Address: _____
Street Apartment #
Person to contact for emergency: _____ Telephone _____
Is another member of your family or relative a patient at our office? _____
Who may we thank for referring you to our office? _____

Responsible Party Information (if different than above)

Relationship to Patient: the patient's spouse parent or guardian other, _____
Name: _____
 Male Female
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Telephone: _____

Insurance Information

Please allow us to copy your Insurance Card

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 services are performed.

Unlike medical offices where you come in and "wait your turn", we schedule appointment times specific to your treatment needs. These times are reserved just for you. If you do not give us adequate notice that you are unable to come – your appointment time is left open and someone who would have liked to come in, would not have been able to do so. **Unless a scheduled appointment is cancelled 24 hours in advance, you will be billed \$50.00 for the missed appointment.**

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.

I hereby give permission to Dr. Riley, Dr. Ezelle, or any assistant they may designate, to take photographs for diagnostic, teaching, or marketing purposes and to enhance the dental record. I agree that these photographs will remain their property. I further authorize them to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in their judgments, dental research, education, or science will be benefited by their use.

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. 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 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 or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

