insight
integrative dentistry

PATIENT INFORMATION

Patient Name _____ Preferred _____ Date _____
Last First MI

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Spouse / Partner name _____

Social Security Number _____ Birth date _____ E-mail _____

Phone home _____ work _____ ext _____ cell _____

What is your preferred method of contact? ☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-mail

May we leave confidential voicemail messages on any of the above phone numbers? ☐ No ☐ Yes If yes, please specify: ☐ home ☐ work ☐ cell

Address _____
Street Apartment / Unit Number

_____
City State Zip Code

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Relationship to Patient ☐ Spouse ☐ Parent ☐ Guardian

Name _____ Preferred _____ Date _____
Last First MI

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Social Security Number _____ Birth date _____ E-mail _____

Phone home _____ work _____ ext _____ cell _____

What is your preferred method of contact? ☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-mail

Address _____
Street Apartment/Unit Number

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for ☐ the patient ☐ the person responsible for payment

Employer name _____ Occupation _____

Address _____
Street Suite

_____
City State Zip Code

Do you have dental insurance benefits? ☐ No ☐ Yes If yes, please present insurance information at first visit.

REFFERAL INFORMATION

Whom may we thank for referring you to our practice? _____

☐ another patient, friend ☐ another patient, relative ☐ medical doctor ☐ dental office
☐ website ☐ school ☐ work ☐ newspaper ☐ yellow pages ☐ other

Please Turn Page Over

Please read the following carefully and sign by the X.

PAYMENT AGREEMENT

- As a condition of treatment by this office, payment is required at time of service.
- Payment may be made by cash, personal check, MasterCard, Visa, Discover or American Express.
- Financing is available through CareCredit and Lending Club; please ask for details.
- Should your account be referred to a third party collection agency, you agree to pay all collection fees, attorney fees and court costs.
- A non-sufficient fund (NSF) fee of $35 will be assessed per payment returned.
- A service charge of 1 ½% per month (18% per annum) is charged on the balance of accounts over 30 days.

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

X _____ Date _____

Signature of patient, parent or guardian

APPOINTMENT AGREEMENT

- Appointments scheduled in our office are customized to each individual patient.
- We would like the consideration of at least a 48-hour business day notice to cancel or change appointments.
- A fee of $100 per hour scheduled will be charged for any failed or cancelled appointments without adequate notice.
- Please keep in mind that we cannot accept cancellations by voicemail after business hours.

I have read the above and agree to the content.

X _____ Date _____

Signature of patient, parent or guardian

ACKNOWLEDGEMENT AND CONSENT

- To the best of my knowledge the information provided is accurate and I understand that it is my responsibility to inform this office of any changes to the information provided.
- I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aides deemed appropriate to make a thorough diagnosis.
- Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed to by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetics embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read the above and agree to the content.

X _____ Date _____

Signature of patient, parent or guardian