

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Gender: \_\_\_\_\_ Marital Status: Single Married  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone (Home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
Best time to call: \_\_\_\_\_  
Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ email address: \_\_\_\_\_  
Current Address (If different from above) \_\_\_\_\_  
Person to call in an emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment  
Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Phone: \_\_\_\_\_  
Your Primary Dental Insurance Co: \_\_\_\_\_  
Secondary Dental Insurance Co: \_\_\_\_\_

### Referral Information

Referral Source: \_\_\_\_\_ May we thank them?  yes  no

### HIPPA Privacy Practices Acknowledgement

I acknowledge receipt of HIPPA Privacy Practices Information concerning this office. I have had the opportunity to ask questions, and I understand the information therein to my satisfaction.

\_\_\_\_\_  
Signature of Responsible Party Date

### 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.

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.

A service charge of 1½% 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six 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 his 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 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. I further give my consent to Dr. Clendenon and his staff to obtain the necessary dental records (x-rays, photographs, study models, lab tests or consultation with other Doctors or Pharmacies with which I have previously used) in order for them to perform a dental examination and render an informed opinion based upon it.

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

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_