New Patient Information

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zipcode:_____

Social Security #:_____ Email:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Relationship to Policy Holder: (Check One) _____Self_____Spouse_____Child

Dental Insurance Company Name:_____

Policy Holder:_____I.D.#:_____Date of Birth:_____

Employer:_____ Group #:_____

Referred By:_____ Last Dental Cleaning:_____

MISSED APPOINTMENTS

If you are unable to keep your appointment, kindly give us 24 HOUR NOTICE. This will allow us to use this valuable time for another patient. A charge of $50 per half hour will be made to patients who fail to follow this policy. This charge must be settled in advance before another appointment is made.

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient Signature:_____Date:_____