MAIN STREET DENTAL

Patient Information

Patient Name: _____ Date: _____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _____

Social Security #:_____ Birth Date: _____ Email _____

Phone (Home):_____ (Work):_____ Ext: _____ Cell:_____

Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time ❑ M ❑ T ❑ W ❑ T

Address: _____
Street Apartment #

_____
City State Zip Code

Name of a Nearest Living Relative Not Living With You:_____ Phone:_____

Referral Information

PLEASE NOTE: *Our greatest compliment is a referral. As a thank you, when referring friends or family, we offer a $25.00 gift certificate/credit towards future treatment. Please take just a moment to fill in this portion of our form.*

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative

❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Name:_____ Date: _____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _____

Social Security #:_____ Birth Date: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? ❑ Yes ❑ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Insurance Plan Name and Address: _____

Secondary

Name of Insured:_____ Is insured a patient? ❑ Yes ❑ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Insurance Plan Name and Address: _____

MAIN STREET DENTAL

Financial Policy / Consent For Services -
Please Read Carefully

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 or credit card 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.

Dental Insurance Or "Dental Assistance," as it should be called, is designed to help pay part of the cost of dental treatment. Dental insurance is NOT designed to pay all the cost of treatment, but rather to be an aid. **Your insurance contract is between you and your insurance company**. We try to help you receive the benefits that you are eligible for.

This office will help prepare the patients insurance forms or assist in making collections from insurance companies – **in return we must ask for Patient's Portion to be paid before or at time services are performed. All co-payments or patient's portion must be paid before patient is brought back to treatment room.**

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 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 and understand Notice of Privacy Practices.

There will be a $75.00 fee for any appointments that are scheduled and missed for any reason other than a true hardship emergency. 48 business hours notice is required to avoid the above fee.

Everyone's time is valuable. We have many patients to care for.

A missed appointment could have been time given to a patient in need.

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

Patient/Guardian Signature: _____ Date: _____