TERHUNE DENTAL

NEW PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)	I prefer to be called (if different than legal name)	Social Security Number
Home Address	City, State, Zip	Birthdate
Marital Status Single Married Divorced Separated	Email Address	Gender Male Female
Home Phone ( )	Work Phone ( )	Cell Phone ( )
Employer	Occupation	

INSURANCE INFORMATION (PLEASE GIVE CARD TO RECEPTIONIST TO SCAN)

Primary Account Holder	Social Security Number	Relationship (if other than patient)
Address	City, State, Zip	Birthdate
Employer	Occupation	Work Phone ( )
Secondary Account Holder	Social Security Number	Relationship (if other than patient)
Address	City, State, Zip	Birthdate
Employer	Occupation	Work Phone ( )

How did you hear about our Office?
(Check only one, please)

Where did you find the Phone Number to this office? _____
Referred by a friend ___ Yellow Pages_____ Relative_____ Insurance Plan_____ Newspaper Ad_____ Sign by Building_____ Other_____
If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge_____ (Initials)
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office I understand financial arrangements must be made in advance. All emergency dental service performed without financial arrangements must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits according to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for 90 days from the date of the patient's exam. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed _____**Date**_____