PERSONAL INFORMATION

Name_____Preferred Name_____
Address_____Postal Code_____
Phone Number(s): (home)_____(work) _____(cell)_____
E-mail_____Referred to our office by_____
Date of Birth (dd/mm/yyyy)_____Occupation_____
Emergency contact person_____Relationship_____
Phone number:_____

Health Insurance Information (if applicable): Please present your health benefits insurance card to receptionist.
Insurance Company_____
Subscriber name & DOB (dd/mm/yyyy)_____Relation_____
Policy / Plan # _____Certificate / ID #_____

Payment Options
Patients are personally responsible for payment of all dental services. All dental services are charged directly to the patient when treatment is rendered.
We offer several different payment options to make your treatment as affordable as possible. For your convenience, we accept **Debit, Visa & MasterCard**. In special circumstances, financing options may be arranged.
For patients with dental insurance coverage, we will complete any required claim forms for your direct reimbursement. If possible, we will electronically submit your insurance claim so that you can receive your rebate payment even faster. Please note: it is the responsibility of the patient/insurance subscriber to understand the benefits & limitations of their dental coverage plan. initials_____

CANCELLATION POLICY
We do require **2 business days** notice to change your appointment or a cancellation fee may apply. initials _____

Personal Information Disclosure Agreement
We are committed to protecting the privacy of our patients' personal information & to utilizing all personal information in a responsible and professional manner.
- Patient personal information is collected and used for the purpose of updating personal profiles, invoicing, processing insurance claims, sending reminders and sending information to patients about out dental practice.
- Patient medical information is collected and used for the purpose of diagnosing dental conditions, treatment planning and providing dental treatment.
- Patient financial information may be collected in order to make arrangements for the payment of dental services provided.

initials_____

Mission Statement: *Your Smile + Our Work = Our Commitment for Better Oral Health!*
Our goal is to treat our patients as a whole based on their needs and wants for optimal dental and overall health. Each team member plays an important part in our success. Our satisfaction comes from patients who appreciate our efforts, care about their health and well-being, and take responsibility for wanting the best level of care for themselves, their family and their friends.

INFORMED CONSENT
I, the undersigned, do hereby authorize and consent to the administration of all dental procedures deemed necessary or advisable for myself, or my child, by the attending dentist, including but not limited to, the use of local anesthetics, or other prescribed medications.
I shall assume the responsibility for payment of all fees associated with treatment procedures provided.
I consent to collection, use and disclosure of my personal information for the purposes outlined in the personal information consent agreement.
I have reviewed the foregoing consent and authorization, and understand its content.

Patient Signature_____Date_____