



## Referral Information

Whom may we thank for referring you to our practice?

- Another patient, friend     Another patient, relative     Another Dental Office     Website / Internet  
 Yellow Pages     WCOA     Blab TV     WEAR (Channel 3)     Q100     Magic 106  
 LumiSmile Preview Card     Welcome Letter     New Patient Post Card     Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

## Person Responsible for Insurance and/or Payment

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

Name: \_\_\_\_\_  
 Male     Female     Married     Single     Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Employment Information

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Consent for Services

We are very happy to have you as a new patient in our office. At Airport Dental, we take a lot of pride in meeting or exceeding our patients' needs. This keeps us very busy, so we do require each patient to read and understand the following procedures that we follow.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment is provided. 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.

Again, because we want to best serve our patients, there will be a charge of \$99.00 for any broken or cancelled appointments if at least 48 hours notice is not given. We are sure you understand that when you miss appointment time reserved specifically for you, other patients in need of treatment cannot be seen.

Patients who carry dental insurance are to understand that all treatment proposals are presented with an estimate of what insurance will cover, not a guarantee. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. This office will electronically file most insurance forms and assist in making collections from insurance companies as a courtesy. Any such collections will then be credited to the patient's account and if there is a remaining balance, it is the responsibility of the patient.

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 treatment plan costs listed for this dental care can only be extended for a period of 30 days from the date of the 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. 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 were instituted hereunder.

I give my permission for this office to take video and photographs to be used for diagnostic, insurance, practice development and advertising purposes.

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.

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