SereneView
DENTAL CARE

ABOUT YOU

Full Name _____ **Preferred Name** _____

Address _____ **City**_____ **State**_____ **Zip**_____

Phone number _____ **Other Phone number**_____

Social Security # _____ **Birthdate (MM/DD/YYYY)** _____

Employer _____ **Occupation**_____

Are you: ☐ **Married** (see below) ☐**Single** ☐**Divorced** ☐ **Widowed** **Email** _____

Spouse Name _____ **Phone number** _____

Employer _____ **Occupation** _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (If other than self)

Name_____ **Address**_____

Relationship _____ **Social Sec. #**_____ **DOB**_____

DENTAL INSURANCE

Insurance Company_____ **ID number** _____

Group number _____ **Phone number** _____

Insured's Name _____ **Insured's DOB** _____

Insured's SSN _____ **Insured's Employer** _____

Insured's Relationship to Patient_____

GETTING TO KNOW YOU

- **Is another member of your family a patient here? If so:**

Name_____ **Relationship**_____

- **How did you hear about us?** _____

- **Whom may we thank for referring you to our office?** _____

- **Emergency contact** _____ **Phone** _____ **Relation**_____

Address _____**City/State/Zip**_____

- **Closest relative not living with you**_____ **Relation** _____

Phone _____ **Address** _____**City/State/Zip**_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or other designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless prior arrangements have been made. I understand that a 1.5% (18%APR) or min of $5.00 service charge may be added to my account if balance is not paid in full within 60 days. I further understand that in the event of a returned check, a $45.00 fee will be assessed. I also understand and agree if this account goes into default, I will be responsible for all court costs, attorney fees and collection fees (of not less than 33.3% of outstanding balance).

5. Your time is as valuable to you as ours is to us. Our philosophy is that the doctor and staff should respect the time you have given us to complete your care. We believe that when you make an appointment in our practice it is a mutual bond of trust that you will be here as well as we will be prepared to see you promptly. For that reason, I understand that a broken appointment fee may be charged to my account unless I give a 48-hour notice. This fee is dependent on the amount of time we have reserved for you.

I have read and understand the above policy, and I agree to the terms above.

Patient signature _____ Date _____

Parent/responsible party's signature _____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I HAVE REVIEWED AND/OR RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

SIGN _____ DATE_____

For office use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but could not obtain because:

____Individual refused to sign

_____An emergency situation prevented from obtaining

_____Communications barrier prohibited obtaining

_____Other (Specify)_____