PATIENT INFORMATION

Date_____

Patient Name_____
(Last) (First) (MI)

Preferred Name_____

Sex □ M □ F Age_____

□ Married □ Single □ Minor □ Other

Birthdate_____ **S.S. #**_____

Driver's License#:_____

Address_____

City_____

State_____ Zip_____

E-Mail: _____

Home Phone #: _____

Work Phone #:_____

Cell Phone #: _____

Patient Employer_____

Who may we thank for referring you?

_____

Family/Friend/Co-worker/Phone Directory/Internet

IN CASE OF AN EMERGENCY, CONTACT

Name _____

Relationship _____

Phone #:_____

Authorization & Release

I authorize and grant permission for the office of Riverside Dental to discuss my personal account and treatment information with the person(s) listed on my account, those providing insurance coverage, payments, or inquiring about records or billing information.

List below any other with whom you authorize your information to be shared:

Name:_____ Phone #:_____

Circle your relationship to patient:

Husband/Wife/Mother/Father/Child/Guardian/POA/Other:

Name:_____ Phone #:_____

Circle you relationship to patient:

Husband/Wife/Mother/Father/Child/Guardian/POA/Other:

I authorize the persons of Riverside Dental to perform diagnostic procedures and treatment as necessary for proper dental care. I voluntarily authorize Riverside Dental to release any of my confidential protected information for me, or my child, including diagnose and the records of any treatment or examination rendered during the period of such dental care, to third party payer and/or other dental, health practitioners.

I have been able to review a copy of this office's Notice of Privacy Practices. Please ask our receptionist for a copy.

(Signature)_____

DENTAL INSURANCE

□ **NO DENTAL INSURANCE**

PLEASE COMPLETE ENTIRE SECTION

Who is responsible for this account? Self/Spouse/Parent/Other

Relationship to patient_____

Subscriber's Name _____

Employer _____

Insurance Co._____

Group #_____Member I.D.# _____

Birthdate _____ **S.S. #**_____

Ins. Address_____

_____ Ins Phone #_____

Is patient covered by additional dental insurance? □ Yes □ No

Subscriber's Name_____

Birthdate _____ **S.S. #**_____

Relationship to patient_____

Insurance Co._____

Group #_____Member I.D.# _____

Ins. Address_____

_____ Ins Phone #_____

Consent for Service

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of patient examination. I agree to pay the charges for rendered services at the time of treatment.

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 unless other arrangements are made.

In consideration for the professional services rendered to me by this practice, I authorize this office will help prepare the patient's insurance forms, or assist in making collections from insurance companies, and understand that Riverside Dental will credit any collections to the patient's account. Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services within 90 days of the date of treatment. We cannot render services on the assumption that our charges will be paid by an insurance company.

Please notify us 24 hours in advance should you need to change an appointment. If you miss an appointment without notification, a $30.00 missed appointment fee will be charged to you.

X_____

Signature of patient, parent, or guardian/POA:

Relationship to patient:_____