MERIDIAN DENTAL CARE — PATIENT INFORMATION

Last Name	First	Initial	Nickname

Birthdate	Social Security #	Male	Female	Married	Single	Other	Child

Address

City	State	Zip

Home Phone	Work Phone	Other

Employer	Driver's License Number	E-mail Address

Head of Household *(If not Patient)*

Name	DOB	SS#	Employer	Employer Phone #

Insurance Information - Primary Insurance

Company Name	Address & Phone #	Group Number

Name of Insured	Date Of Birth	Social Security Number

Secondary Insurance

Company Name	Address & Phone #	Group Number

Name of Insured	Date Of Birth	Social Security Number

Consent for Services:

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

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's 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, or within five (5) days of billing if credit shall be extended. 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 instituted hereunder.

I understand that the cost of the care is my primary responsibility. Meridian Dental Care has agreed to bill my insurance company directly as a service to me. **I understand that the Estimated Patient's Portion is due and payable by me at the time of service. I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient - parent or guardian/ - Responsible Party _____ Date _____

Who may we thank for referring you _____