PATIENT INFORMATION

Name (first) _____ (mi) _____ (last) _____ Preferred Name_____

Whom may we thank for inviting you? _____ E-Mail_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Address_____

Social Security #_____ Date of Birth_____/_____/_____ Sex M F

Emergency Contact: Name _____ Phone _____

What is the best way to contact you? (Circle One) Home Work Cell Email Text Message

RESPONSIBLE PARTY INFORMATION (person signing form only)

Person Responsible for this Account_____ Relationship to Patient_____

Address (if different from above) _____City_____ State_____ Zip_____

Phone (if different from above) Home_____ Work_____ Other_____

Social Security #_____ Date of Birth_____/_____/_____ Currently a Patient Here? Y N

INSURANCE INFORMATION (filed as a courtesy, your portion due at time of service.)

Name of Insured_____ Relationship to Patient_____ Date of Birth_____/_____/_____

Social Security#_____ Employer_____ Phone (_____) _____

Insurance Company_____ Phone (_____) _____ Group # _____

AUTHORIZATION

I authorize Dr. Cha to perform diagnostic procedures such as x-rays and exams to determine the best possible treatment for my (or my child's) oral health. I authorize the doctors to perform dental treatment as may be necessary for optimal oral health. I authorize the use of diagnostic photos and x-rays to inform or educate other professionals or patients.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to other dental and medical professionals, if necessary.

I hereby authorize payment of insurance benefits directly to Dr. Jerome Cha,. I understand that I am financially responsible for all charges whether or not covered or paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made in advance. I accept full financial responsibility for all charges not paid by insurance within 45 days of treatment. I understand that any balance over 30 days old will be subject to a 1.5% monthly service charge.

If payment is delinquent, I agree to pay for all collection agency and attorney's fee (up to 50% of original balance) accrued by collection of payment.

The office reserves the right to charge $134/hour for appointments cancelled or broken without 48 hours of notice.

_____ Signature of Patient or Guardian _____ Date

_____ Print