Patient's Name: ______________________________ Age: _____ Birthdate: ______________ Male ___ Female ___

Parent/Legal Guardian (if patient is a minor): ______________________ Relationship to patient: ______________________

Address: ____ SSN: ______________________

Patient is: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Minor _____ In a Relationship _____ Prefer to not answer

Home phone ______________________ Cell phone ______________________ E-mail ______________________

Employer: ______________________ Occupation: ______________________ How long: __________

Address: ____ Business phone: ______________________

Spouse: ______________________ Address: ______________________________

Employer: ______________________ Occupation: ______________________ How long: __________

Address: ____ Business phone: ______________________

Former Dentist: ______________________ City: ______________ Phone: ______________

Why are you changing dentists? ______________________ Whom may we thank for referring you? ______________________

Name of nearest relative not living with you: ______________________ Relationship: __________ Phone: ______________

Person responsible for this account: ______________________________ Relationship to patient: ______________________

Name of **PRIMARY** Dental Insurance Plan: ______________________ Subscriber's Name: ______________________

Subscriber's Employer (or company, if self-employed): ____

Subscriber's S.S.N: ______________ Member I.D: ______________________ Group # __________ Subscriber's Date of Birth: __________

Name of **SECONDARY** Dental Insurance Plan: ______________________ Subscriber's Name: ______________________

Subscriber's Employer (or company, if self-employed): ____

Subscriber's S.S.N: ______________ Member I.D: ______________________ Group # __________ Subscriber's Date of Birth: __________

____ **I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way.**

____ **I hereby acknowledge that I have received a copy of the DENTAL MATERIALS FACT SHEET as required by law.**

TERMS AND CONDITIONS

As a condition of my dental treatment in this office, I understand that all financial arrangements must be made in advance. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of fees incurred for dental services rendered. If I carry dental insurance, I understand that as a courtesy, this office will help prepare my insurance forms to assist in collecting fees associated with my treatment from the insurance company, and will credit such collections to my account. However, this dental office cannot render services on the assumption that any fees will be paid by the insurance company, and ultimately, it is my responsibility to pay any balance that my insurance company does not cover. If my insurance company reimburses me directly, I agree to pay my balance in full, to Carl J. Dispenziere, D.D.S. at the time services are rendered.

I hereby authorize my insurance company to pay directly to Carl J. Dispenziere, D.D.S. benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum) will be charged on any unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of seven months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by Carl J. Dispenziere, D.D.S. and/or his staff, I agree to pay, therefore, the reasonable value of said services to Carl J. Dispenziere, D.D.S. or his assignee, at the time said services are rendered, or within 10 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time of payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party shall be entitled to recover all costs incurred including reasonable attorney and/or collection fees.

I grant my permission to Carl J. Dispenziere, D.D.S., or to his assignee, to contact me by home phone, cell phone, work phone, or email to discuss the matters related to this form. I have read the above conditions and agree to the content of this form and its conditions. All terms and conditions of this contract will remain valid until I request termination of this contract in writing, and, such request is received by Carl J. Dispenziere, D.D.S.

______________________________ ______________________________ ______________

PRINTED NAME of PATIENT OR LEGAL GUARDIAN **SIGNATURE of PATIENT OR LEGAL GUARDIAN** **DATE**