Panther Hollow Dental Lodge, PL

Patient Information

Patient Name: _____ Date: _____
Last First M. (preferred name)

If Child, Parent's Name _____ Spouse's Name _____

Home Address: _____
Street Email Address

_____
City State Zip Code

Birth Date ____/____/____ Gender: ☐ Male ☐ Female Family Status: _____

Social Security # _____ Driver's Lic. # _____

PHONE: Cell: _____ Home: _____ Work: _____ Emergency: _____

How did you find out about our office? (Circle one) Newspaper Telephone Book Magazine Website Other _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, local or policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate___/___/___ Insured's SS #_____

Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, local or policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate___/___/___ Insured's SS #_____

Insured's Employer: _____

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

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 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 such be instituted hereunder.

I grant my permission to you or you assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party