DENTAL HISTORY

When was your last cleaning? _____

When was your last full mouth x-rays taken? _____

Have you had x-rays in the last 12 months? _____ If yes, list doctor's name & number _____

AUTHORIZATION AND RELEASE

I hereby authorize and request my insurance company to pay directly to the dentist, the amount due on my claim for services rendered to me or my dependent. I further agree that I am financially responsible for all charges whether or not paid by my insruance (this includes any denial of payment). I also hereby authorize the release of any dental information necessary to process my claims, and the use of this signature on all insurance submissions. The dentist office will promptly file all requests for payment to my insurance company. Should the dentist be unable to collect from the insurance within 60 days from the date of service, I will be billed and expected to make immediate payment for services rendered.

X _____

Signature of patient or parent if minor Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.
Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MC

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____

DATE OF BIRTH: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____

Signature Date

Dr. Parsons' office is authorized to release protected health information about the above named patient to the entities named below.

	Name	Relationship to Patient
1.		
2.		
3.		