HARDER DENTAL CORPORATION

CONFIDENTIAL PATIENT INFORMATION
TO BE KEPT CONFIDENTIAL

Patient Name:_____ Pronunciation:_____

Last First Initial

I prefer to be called:_____ Date of Birth:_____ Sex □ **M** □ **F**

Patient is: □ Married □ Single □ Divorced □ Separated □ Widowed □ Partner □ Minor □ Other

Driver's License No.:_____ Social Security No.:_____ Email:_____

Address:_____

Street Apt.# City State Zip

Home No.:_____ Cell No.:_____ Business No.:_____

Preferred Communication: □ Home □ Cell □ Business □ Email

Employer:_____ Occupation:_____ How Long:_____

Address:_____

Street City State Zip

If Patient is a Minor: □ Full time Student □ Part Time Student School:_____

Spouse's Name:_____ Employer:_____

Work Address:_____

Street City State Zip

Occupation:_____ Business No:_____

Who is legally responsible, if other than patient:_____ Relationship:_____

Social Security:_____ Date of Birth:_____ Contact No.:_____

Address:_____

Street City State Zip

Person we can contact in case of emergency (other than family home):_____

Relationship:_____ Contact No.:_____

Who can we thank for referring you to our office?:_____

Other family or friends that are patient's:_____

INSURANCE INFORMATION

Insurance Coverage □ Yes □ No

Insurance Co. Name:_____ Relationship to Patient: □ Self □ Spouse □ Dependant

Address:_____ ID/SSN No.:_____

Street City State Zip

Group No.:_____ Subscriber Name:_____ Date of Birth:_____

Employer (if different than above)_____

Address:_____

Street City State Zip

Secondary Coverage □ Yes □ No

Insurance Co. Name:_____ Relationship to Patient: □ Self □ Spouse □ Dependant

Address:_____ ID/SSN No.:_____

Street City State Zip

Group No.:_____ Subscriber Name:_____ Date of Birth:_____

Employer (if different than above)_____

Address:_____

Street City State Zip

ASSIGNMENT & RELEASE

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in submitting claims to receive benefits from insurance companies and will credit such collections to my account. However, this dental office can not render services on the assumption that charges will be paid by an insurance company. **Assignment of Insurance:** I hereby authorize my insurance company to pay benefits directly to my dentist accruing to me under my policy. A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid balance on all accounts not paid within 60 days of treatment. I understand that the fee estimate listed for this dental case can only be extended for a period of 60 days from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his team, 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 credit shall be extended. I further agree that the reasonable value of said servics shall be billed unless objected by me, in writing, within the time for payment thereof. 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 either this office or I institute any legal proceedings with respect to amounts owed by me for services, the prevaling party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fee's. I grant my permission to you, or your assigns, 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 agree to their content:

Signed Patient or Guardian:_____ Date_____