AMERIDENT GROUP
6555 E. Telephone Rd., Ste. 8
Ventura, CA 93003

PATIENT INFORMATION

(PLEASE PRINT)

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6555 E. Telephone Rd., Ste. 8
Ventura, CA 93003

PATIENT NAME _____
Last Middle First

REFERRED BY _____

MALE☐ FEMALE☐ MARITAL STATUS: SINGLE☐ MARRIED☐ DIVORCED☐ SEPARATED☐ WIDOWED☐

DATE OF BIRTH_____ AGE_____ HOME PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMPLOYER_____ POSITION_____ BUS. PHONE_____

BUS. ADDRESS_____ CITY_____ STATE_____ ZIP_____

S/S #_____ D/L# _____

WHO SHOULD BE NOTIFIED IN CASE OF AN EMERGENCY ?_____ PHONE_____

NAME OF NEAREST RELATIVE OTHER THAN ABOVE_____ _____ PHONE_____

PURPOSE OF THIS APPOINTMENT_____ DATE OF LAST EXAMINATION_____

DO YOU HAVE DENTAL INSURANCE_____ IF YES, NAME OF INSURANCE_____

EMPLOYER _____

IS POLICY CONNECTED WITH YOUR UNION ?_____ IF YES, NAME OF UNION_____

LOCAL NO._____ GROUP NO._____ POLICY NO._____

(It is necessary that you provide Claim Forms for all professional services that may be eligible for insurance coverage)

SPOUSE NAME_____ DATE OF BIRTH_____

EMPLOYER_____ POSITION_____ BUS. PHONE_____

BUS. ADDRESS_____ CITY_____ STATE_____ ZIP_____

S/S#_____ D/L# _____

DENTAL INSURANCE CARRIER_____ GROUP NO._____

TERMS & CONDITIONS

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 making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the 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 six months 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 staff, 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 billed unless objected to by me, in writing, within the time for 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 in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

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: _____ Date: _____

PLEASE COMPLETE BOTH SIDES