New Patient Information

Whom may we thank for referring you to our office?

OGoogle/Facebook **O**Radio **O**Flags **O**Friend or Family **O**Insurance **O**Event

Patient Name: _____ **Today's Date**: _____
Gender: **O**Male **O**Female **Marital Status**: **O**Single **O**Married **O**Child **O**Other
Social Security # _____ **Patient D. O. B.:** _____
Home Address: _____
Street City State Zip Code

Phone (Cell): _____ **Home Phone:** _____
Work Phone: _____ **Emergency Phone:** _____
E-mail Address: _____

May we contact you by Text Message? O Yes **O**No **May we contact you by E-Mail? O**Yes **O**No

Authorized Additional
Guardians: Grandparent: _____ **Aunt or Uncle:** _____
Sibling: _____ **Other Family Friend:** _____

Treatment of a Minor & Financial Consent

I authorize Menta Dentistry to perform the examination and to provide necessary dental services using methods deemed for the care of the above-named child, or adult patient. Due to a variety of situations, a probability of a proposed treatment may change. I will be informed of any change in treatment as they occur, and I will be financially responsible for any changes. This consent shall remain in effect until cancelled by either party. I understand that the information above is correct to the best of my knowledge, that it may be held to the strictest of confidence and that it is my responsibility to inform the office of any changes in my child or my health. I understand that I am responsible for the full cost of necessary dental treatment for my child (or myself if it applies) regardless of insurance coverage. Every effort is being done to keep the dental care services at a minimum. You can help by making a payment in full at the time of your visit. With the exception of emergency dental services, you will be given an estimate of the approximate total fee at the beginning of any necessary treatment and define financial arrangements have been made. I understand that in the event of outstanding balances have to be referred to a collection agency or attorney for recovery; I will be fully responsible for any or all costs, but not limited to the attorney fees. I grant my permission to the dental practice or its assignee to contact me at home or at work regarding this matter or anything related to this matter.

Dental Insurance Authorization & Release of Information

I understand that professional services are rendered and charged to the patient and not to the insurance company. I also understand that this dental office cannot render services on the assumption that the charges will be paid by an insurance company. I understand that I am financially responsible for all costs of dental treatment for my child or I, including any charges not covered in this authorization. If I have active dental insurance at the time of my treatment or my child's, I understand that I will be required to pay my estimated portion for dental treatment at the time of service. The dental practice will extend credit to me by way of submitting the dental claim to my insurance company for benefit payment to the dental practice. I authorize payment of group insurance benefits directly to Menta Dentistry otherwise payable to me. I grant the right to the dental practice to release my child's health history and other information about my child's dental treatment to third party payers and or other healthcare professionals. It is my responsibility to provide the dental practice with the correct insurance information and to know the benefits of my policy. I understand that my dental insurance plan is used to share in the cost of my child's dental treatment. My insurance policy is a contract between me and/or my employer and my insurance company. The insurance company has no obligation to the dental practice. I understand that when I have insurance claims pending, I will receive a monthly statement for the outstanding account balance. The dental practice cannot accept responsibility for collections on claims or for negotiation a disputed claim. The dental practice will file claims only twice for a specific claim with a 30 day grace period. If my insurance company has not made payment to the practice within 30 days of the treatment date, I agree to pay the balance due in full at that time.

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

_____ _____ _____ _____
Signature of Parent/Guardian. Date Signature of Patient if age is 18 and above. Date