

Palm Dental Group

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7733 Palm St, Suite #107 • Lemon Grove, CA 91945



(619)460-1991

SSN _____

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

Name of person, office, or other source referring you to our practice:

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address : _____
Address 1 Address 2
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2
City State Zip Code

Insured's Employer Name: _____

Employer Address : _____
Address 1 Address 2
City State Zip Code

Patient's relationship to insured: Q Self Spouse QChild Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2
City State Zip Code

Insured's Employer Name: _____

Employer Address : _____
Address 1 Address 2
City State Zip Code

Patient's relationship to insured: Self Spouse QChild Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2
City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are

performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient:

Response Date: __ / __ / _____