Matthew Artho, DDS
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Getting To Know You as Our Patient

Date:

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security #	Birthdate:
Cell Phone	Driver's License #	Sex *(circle one)* Male Female
Work Phone	Marital Status *(circle one)* *Single Married Divorced Separated Widowed*	E-mail

Insurance

Primary Insurance Company	Subscriber
Group #	ID #

Responsible Party and/or Insurance Subscriber Information (if different from above)

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security #	Birthdate:
Cell Phone	Driver's License #	Sex *(circle one)* Male Female Relationship to Patient
Work Phone	Marital Status *(circle one)* *Single Married Divorced Separated Widowed*	E-mail
Employer	Business Address	Occupation

How did you learn about our office? *(Please Specify)*____

Consent and Communication

I will answer all health questions to the best of my knowledge. After explanation by the doctor, I hereby authorized the performance of dental services upon the above named patients and whatever procedures the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetic and x-rays as may be deemed necessary and advisable by the doctor. By providing my phone number and /or e-mail address I am consenting to communication by the dental office through these methods. **I understand that a 24 hour notice is required to cancel an appointment or a fee will be assessed.**

Terms and Conditions

The office depends upon reimbursement from the patient for the cost incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time the services are performed. I understand that this office will help prepare 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.

Assignment of insurance: I hereby authorize releases of any information and also authorize my insurance company to pay directly to this office benefits accruing under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given this office. I 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 attorney's fees. I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read and understand the above conditions and agree to their consent. There may be a charge for any missed appointment not cancelled 24 hours before the appointment time.

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Patient/Parent/Guardian Signature (I have read and agree to the content, terms and conditions listed above)