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legacy smiles

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Previous Visit: _____ Email Address: _____

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

If we are unable to contact you because your phone is disconnected, or your voicemail is full or not set up, we cannot guarantee your appointment.

Address: _____
City State Zip Code

Emergency contact name, phone number and relationship to patient: _____

_____

Consent for Services
Assignment of Benefits

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners.

I authorize the payment from insurance carrier to be applied directly to the charges I have incurred.

☐ I have read, understand and agree to the above terms and conditions.

Signature of patient, parent, or guardian: _____ Date: _____

Relationship to Patient: _____

Financial Policy

Thank you for choosing our office as your dental health care provider. Please understand that payment of your bill is part of your treatment. Payment is due at the time service is provided. If you have dental insurance your portion will be estimated and is due at the time of service. We provide co-payment estimates as a courtesy, if for some reason your insurance company does not pay as estimated you are responsible for the remaining balance. We accept cash, check, Visa, Mastercard, Discover, American Express and CareCredit.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

☐ I have read, understand and agree to the above financial terms and conditions.

Signature of patient, parent, or guardian: _____ Date: _____

Relationship to Patient: _____