Irvine Dental Group

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date: _____

Patient's Name _____ Age _____ DOB _____ Sex ____
Last First Initial

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ For How Long? □ Own □ Rent
Street City Zip

Patient is: □ Married □ Single □ Divorced □ Widowed □ Minor **Spouse**: _____

Driver's License No. _____ Social Security No. _____ **Home Tel**: _____

Employed By _____ How Long? _____ Occupation _____

Business Address _____ **Business Tel**: _____
Street City Zip

Insured's Name _____ Date of Birth _____ Social Security No. _____

Employed By _____ How Long? _____ Occupation _____

Business Address _____ Business Tel: _____
Street City Zip

Name of Nearest Relative Not Living with You _____ Relationship _____

Address _____ Contact Telephone No. _____
Street City Zip

Name of Physician _____
Address Telephone

Former Dentist _____
Address Telephone

Purpose of Appointment _____

Is this visit for Emergency Dental Care? □ Yes □ No If yes, please explain _____

Email Address _____ **Mobile Phone Number** _____

Whom May We Thank for Referring You? _____

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 at the time services are performed. Patient understands that dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. I f patient carries insurance, it is understood that this office will help prepare insurance forms to assist in making collections form insurance companies and will credit such collections to patient's account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. It is understood that the fee estimates 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. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further terms or conditions. 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 attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or work. I have read the above conditions of treatment and agree to their content.

Signed _____ Date _____