Patient Information

Art Dental Clinic Inc.
General & Cosmetic Dentistry
12600 SW 120th ST Suite: 114
Miami Fl 33186
Ph:305-971-7773 Fax:305-971-7882

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

1

Name: Last First Middle Int. | Home Phone: *Include area code* ( ) | Cell Phone: *Include area code* ( )

Spouse: | Your Business Phone: *Include area code* ( )

Address: Mailing address | City: | State: | Zip:

Date of birth: Age: | Sex: M F | ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor

Social Security No. | Email Address

DENTAL INSURANCE *Accurate insurance card required at time of service*

Should we assist in submitting insurance forms? ☐ **YES** ☐ **NO**

2

Primary Carrier * Please provide us with a copy of your insurance card.

Plan No. | Insurance Carrier | Employee | D.O.B.

Relationship to Insured | Employee SS# - - | Insurance ID No.

ACCOUNT INFORMATION

Preference of payment ☐ Cash on day of treatment ☐ Visa # _____ ☐ Mastercard # _____

3

Person financially responsible for account | D.O.B.

Name: | SS#: | Occupation:

Employer: | Employer Address: | Business Phone: ( )

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office? ☐ **YES** ☐ **NO** If yes, their name:

4

Who can we thank for referring you?

	Phone No:	Address:	City:	State:	Zip:
Person or emergency contact:	( )				
Closest relative not living with you:	( )				

TERMS & CONDITIONS Payment is due at time of treatment unless other arrangements have been approved.

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- 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 in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my 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.
- A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charge on the unpaid principal balance on all accounts not paid within 60 days of treatment.
- I understand that the fee estimate listed for this dental case 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 fifteen (15) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute 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 at my work to discuss matters related to this form.
- I have read the above conditions of treatment and agree to their content.

Signed: _____ **Relationship:** _____ **Date:** _____