Chip L. Hill, D.D.S.

Patient Information

Patient Name ______________________________ Date: ____________
Last First MI

Male Female Marital Status: Married Partnered Single Divorced

Social Security # ______________________________ Birth Date ____________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Preferred appointment times: Morning Afternoon Evening Anytime M T W T

Address: ______________________________
Street Apartment #

____
City State Zip Code

Who can we contact in case of an emergency? ______________________________
Name Address Phone #

Please list any medications you are currently taking:

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Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, family

Dental Office Yellow pages School Work Other __________

Name of the person or office referring you to our practice: ______________________________

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name ______________________________ Date: ____________
Last First MI

Male Female Marital Status: Married Partnered Single Divorced

Social Security # ______________________________ Birth Date ____________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer's Name ______________________________ Occupation: ____________

Address: ______________________________
Street City State Zip Code

Insurance Information

Primary:

Name of Insured: ______________________________ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: ____________ ID#: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other ____________

Insurance Plan Name and Address: ____

____

Secondary:

Name of Insured: ______________________________ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: ____________ ID#: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other ____________

Insurance Plan Name and Address: ____

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Consent for Services

As a condition of your treatment by this office, 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 the 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office does not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of sixty (60) days from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 further acknowledge that I will pay fifty dollars ($50.00) per hour of time allotted for me or my dependent, in the event I do not give 2 business days notice to reschedule or cancel any appointment I have made with this office.

I grant my 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 the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature guarantor of payment/responsible party