INFORMATION AND CONSENT

Patient Name: _____ Birthday(DD/MM/YYYY): ___ /___/_____

Preferred Nickname: _____ eMail: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Whom may we thank for referring you to our practice: _____

Please complete the insurance information below or if NO insurance check the box ☐

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insured Name		Insured Name	
Insurance Company		Insurance Company	
Group #		Group #	
ID#		ID#	
Dependant #		Dependant #	
Birthday of Insured (DD/MM/YYYY)		Birthday of Insured (DD/MM/YYYY)	

CONSENT FOR SERVICES

Please be advised that we are a non-assignment fee for service dental practice. We require payment for all services when rendered but rest assured we will submit all dental claims on your behalf to your insurance company. You can expect payment from your insurance plan typically within 24-48hrs with direct deposit. It will be your responsibility to pay for any treatment not covered by your insurance company.

A service surcharge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial agreements are satisfied. I understand that that the fee estimate listed for dental care can only be extended for a period of six months from the date of the 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, or within (5) 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 of payment thereof. I also grant permission to share this information with any respective insurance company for the purposes of manual or electronic submission.

I have read the above conditions of treatment and payment and agree to their content. Check Box Below ☐

_____ _____/_____/_____

Name of patient, parent or guardian Date (DD/MM/YYYY)