Media Center Dental

Patient Information & Agreement

Patient

Patient's Name:_____ Patient's Birthday:____/____/____
Last First Initial

Residence Address:_____
Street (No P. O. Boxes Please) Apt/Unit City State Zip Code

Social Security #:_____-_____-_____ Driver's License #:_____ State Issuing Driver's License:_____

Work Phone:(___)_____ Ext:_____ Cellular:(___)_____ Home Phone:(___)_____

Employer's Name:_____ Occupation:_____

Employer's Address:_____
Street Apt/Unit City State Zip Code

Financially Responsible Person (If Not Patient)

Name:_____ Date of Birth:____/____/____
Last First Initial

Relationship to Patient: [ ] Parent [ ] Legal Guardian [ ] Other:_____

Residence Address:_____
Street (No P. O. Boxes Please) Apt/Unit City State Zip Code

Social Security #:_____-_____-_____ Driver's License #:_____ State Issuing Driver's License:_____

Work Phone:(___)_____ Ext:_____ Cellular:(___)_____ Home Phone:(___)_____

Employer's Name:_____ Occupation:_____

Employer's Address:_____
Street Apt/Unit City State Zip Code

Insurance

Primary Insurance Carrier:_____ Phone:(___)_____

Employee's Name:_____ ID#:_____ Date of Birth:____/____/____
Last First Initial

Employer's Name:_____ Group #:_____

Employer's Address:_____
Street Apt/Unit City State Zip Code

Secondary Insurance Carrier:_____ Phone:(___)_____

Employee's Name:_____ ID#:_____ Date of Birth:____/____/____
Last First Initial

Employer's Name:_____ Group #:_____

Employer's Address:_____
Street Apt/Unit City State Zip Code

Referral Source

How did you learn about us?

[ ] Yellow Pages [ ] Insurance Booklet [ ] Physician [ ] Other Dentist [ ] Friend [ ] Business Associate

[ ] Existing Patient [ ] Other:_____

Name of Referral Source:_____ **Thank You!!**

Financial Terms And Conditions For Dental Treatment

In consideration for the dental services rendered and costs incurred by Nancy Lee, DDS, Inc., a CA Prof. Corp. ("Dentist"), I agree all charges related to dental services, supplies and costs are due and payable at the time the services are performed. If alternative payment arrangements are desired, I agree that such arrangements must be made in advance of treatment and in writing signed by both parties. If any alternative payment terms are agreed to, those terms shall only supplement these terms and shall not alter these terms except as to time of payment. Unless other payment arrangements are agreed to, amounts unpaid after 60 days from the time the services are performed, or supplies or costs incurred, shall be subject to a monthly service charge of 1.5% (18% annually), but in no event more than the maximum rate permissible under state or federal law.

Dentist is pleased to provide a fee quote for any treatment. However, I agree that any fee quote is subject to change due to any number of known or unknown variables. Furthermore, I agree that any fee quote shall only be valid for a period of 90 days. I agree that missed appointments by me (or the patient) without at least 48 hours prior notice will be charged at the then posted rates, that there will be a charge for all returned checks at the then posted rates and that there will be a charge for each set of x-rays and/or study models created at the then posted rates.

I agree that Dentist, or its staff, are not responsible for any new developments in treatment necessitated by any changing physical condition, accident or poor cooperation by me (or the patient)(e.g., missed appointments, postponed appointments, delay and/or abandoned treatment, poor oral hygiene, failure to strictly follow dental advice, etc.). I agree that neither Dentist, nor its staff, can guarantee, promise or represent a result of any treatment or procedure due to numerous variables, both known and unknown. I agree that no member or representative of Dentist may provide any such guarantee, promise or representation of results at any time, without exception.

If insurance coverage is available, I understand that Dentist shall file an insurance claim as an accommodation on behalf of me (or the patient). Any amounts received from insurance coverage shall be credited to my account (or the patient's account). **I UNDERSTAND AND AGREE THAT PAYMENT FOR ALL SERVICES, SUPPLIES AND COSTS RENDERED IS MY PRIMARY RESPONSIBILITY, WHETHER INSURANCE PROVIDES COVERAGE OR NOT. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES, SUPPLIES AND COSTS NOT PAID BY THE INSURANCE CARRIER. THE INSURANCE COMPANY SHALL HAVE 60 DAYS TO PAY ANY CLAIM AND, IF THEN NOT PAID, I UNDERSTAND THAT THE DENTIST SHALL SEEK PAYMENT DIRECTLY FROM ME AND I SHALL THEN PAY THE DENTIST.**

I authorize Dentist to apply for benefits on behalf of me (or the patient) for covered dental services and supplies rendered, and costs incurred, and I authorize my insurance company(ies) identified from time to time to pay directly Dentist for all dental services, supplies and costs incurred, that are covered by insurance.

I certify that the information I have provided on the reverse side is presently correct and I further agree to immediately notify, in writing, Dentist if there is any change in my information, whether insurance or otherwise, that affects any dental services, supplies or costs rendered, or to be rendered. I authorize the release of any necessary information, including medial or dental information, related to any proposed or actual treatment, to the insurance company(ies) provided on the reverse side, or as otherwise updated. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the insurance company(ies) at any time in writing.

I authorize Dentist to perform presently and thereafter from time to time visual examination(s) of my mouth and to take radiographic exposures to assist in diagnosis and determination of treatment plan(s). I agree and acknowledge that it is important to strictly comply with any and all treatment plan(s) and dental instructions. I further agree and acknowledge that neither Dentist, or its staff, are responsible for any new developments in treatment necessitated by any changing physical condition, accident or my poor cooperation (e.g., missed appointments, postponed appointments, delay and/or abandoned treatment, poor oral hygiene, failure to strictly follow dental advice, etc.). If the patient is a minor or subject to legal guardianship or conservatorship, then the parent or legal representative further agrees and acknowledges he/she shall ensure that the patient strictly complies with any and all treatment plan(s) and dental instructions. I hereby acknowledge receipt of, or my availability to, the Dental Materials Fact Sheet from the Dental Board of California.

This agreement contains the entire agreement of the parties and supersedes any prior agreement, statement or representation with respect to the subject matter. Waiver of any breach, obligation or condition shall be in writing and such waiver shall not be construed as a waiver of any subsequent breach, obligation or condition. **This agreement may be modified only by a written modification, referring to this agreement, signed by both of us. Only an officer of the Dentist has authority to sign on behalf of the Dentist.** This agreement shall be binding upon any successor, heirs or assigns of the parties. If Dentist, or its assignee, shall make any efforts to collect any monies due from me, Dentist, or its assignee, shall be entitled to recover reasonable attorneys' fees and costs.

_____ Dated:_____/_____/_____

Signature of Patient or Financially Responsible Person

_____

Please Print Full Name