WINTERHOLLER DENTISTRY
IMPLANTS | COSMETIC | TMJ | ORTHODONTICS

Patient Information

Patient Name:_____ Date:_____
❑ M ❑F ❑Married ❑Single ❑ Minor
Social Security #:_____ Birthdate:_____
Home: (_____ Work: (_____
Cell: (_____ Email:_____
Address:_____
City:_____ State:_____ Zip:_____

Employer Name:_____ Occupation:_____
Address: _____
Street State City Zip

Preferred appointment times: ❑Morning ❑Afternoon ❑Evening

Insurance Information

Primary
Name of Insured:_____ Is Insured a patient? ❑Yes ❑No
Insured's Birth Date:_____ ID#:_____ Group #:_____
Insured's Address:_____
Street City State Zip
Insured's Employer Name:_____
Address:_____
Patient relationship to Insured: ❑Self ❑Spouse ❑Child
Insurance Plan Name and Address: _____

Consent of Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on the 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 previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry 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 cannot render service on the assumptions that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 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 six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor. I agree to pay therefore the 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. 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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
THERE WILL BE A $92 DOLLAR FEE CHARGE, for appointments not cancelled 48hrs in advance.
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 of Guarantor of payment or responsible party