



GENTLE CARE DENTAL  
Professional Dentistry... with a heart  
(323) 264-8834  
www.gentlecaresdental1@yahoo.com

# PATIENT INFORMATION

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  MALE  FEMALE

If patient is a minor, give name of parent or legal guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Residence Address \_\_\_\_\_ For how long? \_\_\_\_\_  Own  Rent

STREET CITY ZIP

Patient is:  Married  Single  Divorced  Separated  Widowed  Minor E-Mail Address \_\_\_\_\_

Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Employed by \_\_\_\_\_ Business Address \_\_\_\_\_ Work Phone( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Employed by \_\_\_\_\_ Business Address \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Complete Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

I have no physician

Name of Physician \_\_\_\_\_ ADDRESS \_\_\_\_\_ Phone( ) \_\_\_\_\_

Why are you changing dentist? \_\_\_\_\_

Is this office visit for Emergency Dental Care?  Yes  No Yes, Explain \_\_\_\_\_

School Children Attend \_\_\_\_\_ **Whom may we thank for referring you?** \_\_\_\_\_

## FINANCIAL INFORMATION

Person responsible for this account \_\_\_\_\_  Insurance  NO Insurance

Name of insurance \_\_\_\_\_ company (primary insurance)

INSURED PERSON NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NO
Name Of Group Dental Plan	Group Np.	Name of Union	Local
<b>Name of Insurance Company ( Secondary Insurance)</b>			
INSURED PERSON NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NO
Name Of Group Dental Plan	Group NO.	Name of Union	Local

## TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the cost incurred in their care and financial responsibility on the part each patient must be determined before treatment. All emergency dental services, or dental service performed with out a financial arrangements, must be paid in cash at the time services performed. I understand that dental services furnished to me are charged directly to me and that I am responsible for payment of all dental services. If I carry Insurance that this office Assumption that charges will be paid by Insurance company.

ASSIGNMENT OF INSURANCE: I hereby authorize company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 1/2 % per month ( 18% per annum ) ( but in no event more than the maximum rate permissible under state law ) will be change on the unpaid principal balance on all accounts not paid with in 60 days of the treatment date.

I understand that the fee estimate listed for the dental case only be extended for 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 agreed to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or with in five (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, with in 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 institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing, the party in such proceedings shall be entitled to recover all cost incurred including reasonable attorney's and/or collection 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 \_\_\_\_\_ Date \_\_\_\_\_

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