

Patient Information

Date _____ Responsible Party Social Security # _____

Responsible Party _____ Telephone _____ / _____ / _____

Home Business e-mail

Patient Name _____ Telephone _____ / _____ / _____

Home Business e-mail

Patient Date of Birth _____ Age _____ Sex _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Employer Name and address _____

Occupation _____

In case of emergency Contact: Name, Address and Phone Number of Relative or Friend: _____

Name of Referring Dentist _____

Office Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. 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 at the time services are rendered. Payment is due on your initial consultation (first visit), as well as your periodontal maintenance and any insurance reimbursement will be directed to the patient.

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 insurance forms for our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 45 days from the date of service unless previously written financial arrangements are satisfied. I understand that fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional service rendered to me, or at my request for a minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist and his assignee at the time said services are rendered, or within thirty (30) 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 shall be instituted hereunder to collect monies owed by me, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Mark L. Mangelson D.D.S, M.S., PC

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the condition outlined hereon.

Signature of patient Date

Signature of responsible party other than patient Date Relationship