GREAT LAKES DENTAL CENTER
PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: _____/_____/_____
Last First Middle Initial

Address: _____ **Male** _____ **Female** _____ **Status: S M W D Other**

City:_____ **State**: _____ **Zip**:_____

Social Security Number: _____**Phone #** : _____**Cell#**:_____

Email address: _____

Patient Employer: _____ **Work #**: _____

Address: _____**Occupation**: _____

Spouses Name:_____ **Date of Birth**: ____/____/____ **Social Sec. Number**:_____

Spouses Employer: _____ **Referred by**: _____

In case of emergency contact: Name: _____ **Relationship:**_____

Phone #:_____

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Person responsible for this account? _____**Relationship to patient?**_____

Dental Insurance Company: _____**Group #**_____

Subscriber's Name: _____**ID #**_____**Date of Birth:** _____/____/_____

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I hereby acknowledge that I have received/offered a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

Patient Name: _____ **Patient or By signature:** _X_____

Relationship to patient: _____ **Date:** ____/____/_____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time the services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I assume and agree to be responsible for reasonable administrative fees (30%), reasonable attorney fees, filing fees, court costs and any other costs incurred while collecting the principal amount due and owing if my account enters a default status.

_X_____Signature of Patient, Parent, Guardian or Personal Representative