Please print name_____ **Birthdate**_____

Please tell us how you heard about us_____

Gender (M / F) Marital Status_____ **Social Security #**_____

Home address_____

City_____ **State**_____ **Zip**_____ **Home #**_____

Mailing address_____**Cell #**_____

Northern address_____ **Northern Phone #**_____

E-mail address_____ **Driver's License #**_____

Occupation_____ **Employer**_____

Business Address_____ **Work #**_____

Person to Contact in an emergency_____ **Phone #**_____

If married Spouses name_____ **Social Security #**_____

Birthday_____ **Their occupation**_____ **Their employer**_____

Their business phone #_____ **Their phone #**_____

Do you have Dental Insurance?_____ **Insurance Company Name**_____

Group #_____ **ID # or SS # of policy holder**_____

Subscriber name_____ **Do you have a secondary insurance?**_____

So that we may be able to process your insurance, please give your dental insurance card to the front desk to copy.

Please read the following carefully

By signing below I will be giving my permission for Bradley H. Reiner, DMD and/or Dr. Siera Reiner, DMD and/or the staff to: 1.) Perform mutually agreed upon dental procedures on the person specified as the patient above. If this patient is a minor, I am the legal guardian. We would like all minors to be accompanied by their legal guardian at all appointments. If your minor is of driving age and arrives without you, then you are giving us permission to perform dental treatment on your minor in your absence. In these cases, please make all financial arrangements prior to the day of the appointment. This will avoid your minor making financial decisions on your behalf. 2.) Take xrays, study models, clinical tests, or any other modalities deemed appropriate to us to make a thorough diagnosis of the patient's needs. 3.) Take photographs of the patient that are related to their treatment and to allow the use of these photos in before and after comparisons, educational programs, advertising and scientific publications. It is the usual policy of the practice not to reveal the identity of our patients in these circumstances. 4.) Discuss the patient's medical condition and/or history with other health care professionals and/or insurance companies. 5.) Give or attain any medical records that may be needed for medical or insurance reasons. 6.) Choose and employ any procedure deemed necessary by us to provide safe treatment. Please note that even though dental treatment is very safe, it does embody some risks (novocaine, stress…). 7.) Authorize an investigation of my credit record through Credit Data Services, Inc./TRW. 8.) Receive direct payment from the insurance company for qualifying dental treatment. This means that even though we are not involved in the contract between you and your insurance company, we will as a courtesy try to estimate what portion of your balance the insurance company will cover. We ask that you pay the entire portion of your first visit, after that we will be happy to send in your claims and ask the insurance company to pay their portion to us directly. The day of your appointment we will ask that you pay only the estimated portion not covered by the insurance. If at the end of sixty days the insurance company has not paid the claim, we may ask you to pay the portion the insurance has not paid and arrange for the insurance to reimburse you. I understand that all payment responsibilities for dental services provided to this patient is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge per month (18%APR) may be added to my account. I have had an opportunity to ask questions about these conditions.

Patient Signature_____ Date_____

Parent or Responsible Party_____ Relationship to patient_____