PATIENT INFORMATION (CONFIDENTIAL)

CHECK APPROPRIATE BOX: Mr. __Mrs. __ Miss __ Ms. __ DATE_____
NAME_____ SOC. SEC #___-__-_____
FIRST MI LAST
HOME PHONE # _____ CELL PHONE # _____ EMAIL _____
ADDRESS_____CITY_____STATE____ZIP_____
PATIENT'S OR PARENT'S EMPLOYER _____WORK #_____
BUSINESS ADDRESS_____CITY_____STATE___ ZIP _____
SPOUSE OR PARENTS NAME_____EMPLOYER_____WORK#_____
IF COLLEGE STUDENT: FT/ PT (CIRCLE) NAME OF SCHOOL _____

PERSON TO CONTACT IN CASE OF ANEMERGENCY_____#_____

WHOM MAY WE THANK FOR REFFERING YOU?
_____

ALL PATIENTS PLEASE READ AND SIGN BELOW
AUTHORIZATION FOR TREATMENT & FINANCIAL CONSENT FOR SERVICES

I hereby grant permission to be treated by DAVID P. VIOLETTE, D.D.S., P.C. and staff as providers of dental services. I understand that during treatment, it may be necessary to modify a certain procedure due to conditions found that were not apparent during the initial clinical and radiographic examination. **In consideration of professional services rendered to me, I agree to pay for dental services and/or estimated insurance co-payments at the time these services are provided.**

Patients who carry dental insurance understand that all dental services provided will be charged directly to the patient and that the patient or RESPONSIBLE PARTY as indicated above will be personally responsible for payment of all dental services. **This office cannot render services on the assumption that our charges will be paid by an insurance company.** When requested, this office will assist in making collections from insurance companies by preparing and submitting the patient's insurance forms and will credit any such collections to the patient's account. If applicable, I authorize the release of my " Protected Health Information" to process my insurance claims.

In addition, I understand that all unpaid balances over 30 days will be subject to a service charge of 1.5% per month (18% per annum) unless previously written financial arrangements are satisfied. Furthermore, I understand that I would be responsible for any attorney fees and court costs should this account be turned over to a collection agency.

Appointments represent reserved time with the Doctor or the hygienist. We request that you give this office at least 24 hours notice if you need to cancel or change an appointment. In this regard, this office reserves the right to charge the patient for an appointment missed without a minimum advanced notice of 24 hours. Thank you for your confidence and cooperation.

I have read the above conditions for treatment and payment and agree to their content.

Signature _____
Patient, Parent/Guardian, Responsible Party

Relationship to Patient: _____ Date: ___/___/___