PATIENT INFORMATION
MOUNTAIN VIEW DENTAL CARE

PATIENT:

NAME_______________________________________HOME PHONE_____________________
ADDRESS_______________________________CITY______________STATE_____ZIP_________
SOCIAL SECURITY # __________________BIRTH___/___/___ E-MAIL____________________
EMPLOYER___________________ADDRESS____
OCCUPATION__________________ BUSINESS PHONE____________CELL__________________
WHOM MAY WE THANK FOR REFERRING YOU?____

SPOUSE/PARENT:

NAME______________________________EMPLOYER_____________________________________
EMPLOYER ADDRESS________________________________E-MAIL___________________________
BUSINESS PHONE__________________CELL_________________OCCUPATION_______________

INSURANCE:

NAME OF POLICY HOLDER__________________________BIRTH___/___/___S.S. #_____________
NAME OF DENTAL INSURANCE COMPANY____________________GROUP #_____________________
ADDRESS____PHONE_____________________

SECONDARY OR DUAL COVERAGE?_____NAME OF COMPANY_____________________________
ADDRESS_________________________________POLICY HOLDER__________________________
BIRTH___/___/___S.S.#________________GROUP #__________________PHONE_______________

TREATMENT AUTHORIZATION AND CONSENT

I understand that the above information is necessary to provide the undersigned with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist or hygienist of any changes in my health or medication.

The undersigned authorizes Mountain View Dental Care to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs and to perform treatment, provide medications, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. Mountain View Dental Care may use my health care informatior to obtain payment for services and to determine insurance benefits from the above-named insurance company (ies). I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor, and that I am fully responsibl for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I authorize the use of my signature on all insurance submissions and I assign all insurance benefits to the Mountain View Dental Care. Any payments received by this office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any balances 60 days past due. If it becomes necessary to forward my account to a collection agency, in addition to the amount owed I will be responsible for the cost of collection. If it becomes a legal cost then I will be responsible for all reasonable court costs and attorney fees..
CANCELLATION/"NO SHOW" POLICY: a 24-HR notice is required to change or cancel an appointment. Regretfully, a minimum $50.00 charge will be assessed at Mountain View Dentals discretion.

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Signature Date