DR. STEPHANIE GRUENES
Center for Cosmetic Dentistry
YOUR PERFECT SMILE STARTS HERE
763.262.SMILE (7645) / 763.262.2345 fx / 866.262.7645 / www.beckersmile.com
13734 First Street / PO Box 38 / Becker, MN 55308

PATIENT INFORMATION:

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: Last | First | MI | Preferred Name

Title (Mr/Ms/Mrs/Etc): Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: SS# Prev. Visit:

Email address: Best time to call:

Phone: Home | Work | Ext | Mobile | Fax | Other

Address:

City | State | Zip Code

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:

City | State | Zip Code

Occupation:

Please list the name and phone number of the person we should contact in case of emergency:

Whom may we thank for referring you to our office?

Why did you select our office?

RESPONSIBLE PARTY INFORMATION:

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last | First | MI | Preferred Name

Title (Mr/Ms/Mrs/Etc): Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: SS# Prev. Visit:

Email address: Best time to call:

Phone: Home | Work | Ext | Mobile | Fax | Other

Address:

City | State | Zip Code

Employer Name: Phone:

Address:

City State Zip Code

Is the responsible party currently a patient in our office? ◯ Yes ◯ No

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured:

Last First MI

Insured's Birth Date: ID # Group #

Insured's Address:

City State Zip Code

Insured's Employer Name: Phone:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

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 in cash at the time 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 or 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.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the treatment presentation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent or guardian (responsible party): _____ Date:

Relationship to patient: Response Date: