Patient Information

DAVIES GENERAL DENTISTRY

Patient's Full Name_____ □ Male □ Female

Nickname (if preferred) _____ Birth Date_____ Social Security Number_____

Patient's Status □Single □Married □Widowed □Divorced □Separated □Domestic Partner □Child

Phone (Home) _____ (Cell) _____ (Work) _____

Email_____Preferred number to be contacted: Home Cell Work

Home Address_____Preferred time to be contacted: AM PM

City, State, Zip_____

Patient's Employer _____Patient's Occupation_____

Employer's Address_____

How did you hear about our office? _____

Person Financially Responsible ☐ check if same as above

Full Name_____ Birth Date_____ Phone_____

Address _____

City, State, Zip_____

Financial Agreement

Full payment or Insurance Co-payment and Co-insurance (your estimated portion) is due at every appointment

Payment Options
Several payment options are available to assist you in fulfilling your financial obligations;

We accept: Cash, Check, VISA, MasterCard, or Discover

We also accept CareCredit Credit Card, offered thru GE Capital Retail Bank, a third party lending institution.
For more information about CareCredit, check online at CareCredit.com.

Broken/Cancelled Appointments
Since our time with our patients is very precious to us and lost time is irretrievable, we reserve the right to charge for broken/cancelled appointments when we have not been notified at least 24 hours in advance. Our charge for broken/cancelled appointments is $50. Our desire is never to find it necessary to make this charge. Please keep your appointment, we are waiting for you.

Additional Information
The policy of this office is to charge 1% monthly interest (12% annual percentage rate) that will be applied to all accounts 60 days or more past due. Any account 90 days past due may be turned over to a collection agency. Fees incurred to collect payment will be billed to and payable by the responsible party on the account.

We charge $40 for returned checks.

Financial Consent

I understand that I am responsible for full payment of all treatment performed at Davies General Dentistry.

I understand and agree to the information provided in this Financial Agreement.

Print Name_____

Signature_____Date_____