PATIENT INFORMATION

NAME _____DATE OF BIRTH _____

SOCIAL SECURITY# _____

ADDRESS _____CITY _____STATE _____ZIP _____

HOME TEL # _____ CELL TEL # _____

WORK TEL #_____

EMAIL ADDRESS (We send email reminders)

_____

REFERRAL SOURCE: HOW DID YOU HEAR ABOUT US? _____

EMPLOYER _____ OCCUPATION _____

NAME OF SPOUSE _____ SPOUSE EMPLOYER _____

DRIVERS LICENSE # _____ STATE_____EXP. DATE _____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?

NAME _____EMERGENCY TEL# _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSUARNCE	**SECONDARY DENTAL INSURANCE**
POLICY HOLDER _____	POLICY HOLDER _____
DATE OF BIRTH _____	DATE OF BIRTH _____
INS. CO. NAME _____	INS. CO. NAME _____
POLICY OR SOCIAL SECURITY # _____	POLICY OR SOCIAL SECURITY # _____
GROUP # _____	GROUP # _____
EMPLOYER _____	EMPLOYER _____

PATIENT CONSENT AND AGREEMENT

I hereby give my permission to Optimal Family Dental LLC and their staff ("OFD"') to do all such things as they deem necessary to diagnose, treat and care for my dental needs.

I also give my permission to OFD to furnish any insurance company obligated to me, or any welfare or relief organization, or any political subdivision to which I have applied or may subsequently apply for aid, any and all information with respect to any illness or injury, medical history, consultation, treatment or copies of such with respect to me and my family.

I understand and agree that even if I have dental insurance, I am personally responsible for paying for all services provided to me by OFD irrespective of whether my insurance company covers the service provided. Unless I have paid in full for all services provided to me at the time of service, I hereby authorize my insurance company to pay directly to OFD the benefits which would otherwise be payable to me. I understand and agree that even if I have dental insurance, OFD has the right to require me to pay for a portion of the dental services provided to me by OFD at the time services are rendered. This portion may be referred to as an estimated co-payer patient portion or deductible. I further understand that if the total monies paid to OFD by me and my insurance company is less than the fees for services provided by OFD, I am personally responsible for making up the difference. If the total monies paid to OFD by me and my insurance company is greater than the fees for services provided by OFD, the excess will be credited to my account and/or refunded to my insurance company or me. I further agree to pay for all legal and/or collection fees associated with the collection of any balance on this account(s). I understand that it is my responsibility to verify with my dental insurance company that a particular Dentist or Specialist is a participating provider in my dental plan. OFD will make a reasonable attempt to assist me in this process, but the selection will ultimately be my responsibility. I understand that my dental coverage may require me to pay a greater co pay (patient portion) if I decide to have my treatment provided by a Dentist or Specialist who is not participating in my dental plan.

I understand and agree that all clinical notes and x-rays taken remain the property of OFD. If I find it necessary to obtain a copy of my records, there will be a charge for that service which I agree to pay. I understand and agree that with dental services, as with any other treatment of the body, the results are not always expected, desired or successful and that no guarantees are or can be made as to the result of any dental treatment or series of treatments.

I have read and understand this form and in signing below I indicate my agreement with same.

Signature of Patient _____

Date _____

Person Financially Responsible for this Account, if patient is a minor (under age 18),

_____Date_____

Signature of the Patient's legal guardian