

Patient's Name _____ Date ____/____/____
 Birth Date ____/____/____ Age ____ SSN ____/____/____ Marital Status _____
 Address _____ City/State/ZIP _____
 Home Address _____
 City/State/ZIP _____
 E-mail address _____
 Phone (____) ____-____ Mobile Phone (____) ____-____ Work Phone (____) ____-____
 Insurance Company _____ ID # _____ Group# _____
Employer _____ **Occupation** _____
 Business Address _____ Phone (____) ____-____
 City/State/ZIP _____
Spouse/Partner Name _____ **Spouse/Partner Employer** _____
Person Responsible for Account: _____ Phone (____) ____-____
 Address _____ City/State/ZIP _____
 Phone (____) ____-____ Mobile Phone (____) ____-____ Work Phone (____) ____-____
Name of nearest relative not living with you: _____
 Address _____ City/State/ZIP _____
 Whom may we thank for referring you: _____
 How did you hear about us? Newspaper Yellow pages Internet Mailer Radio Other _____

FINANCIAL POLICY

The following is an outline of payment options offered by Dr. Henry:

- ❖ BOOKKEEPING DISCOUNT: Payment in full at the time of service will receive a 5% discount on Cash/Check only
- ❖ We accept: Cash, Check, Discover, MasterCard and VISA (we do not offer the 5% discount on credit/debit cards)
- ❖ We Offer CareCredit. Ask us how to apply.

In accordance with the Federal Truth-in Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office.

The responsible party agrees:

1. To pay the doctor at time of treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 90 days from the date of first billing, to pay 2% per month on the unpaid balance (annual rate of 24%) with a minimum charge of \$5.00 per month. **CREDIT CHECKS MAY BE RUN.**

I/WE AGREE TO PAY COST AND /OR REASONABLE ATTORNEY'S FEES IF ANY DELIQUENT BALANCE IS PLACED WITH AN AGENCY OR ATTORNEY FOR COLLECTION OF SUIT.

DATE ____/____/____ Responsible Person _____

Consent for Treatment

I hereby grant permission for dental work to be performed on myself or the named patient below (if patient is a minor) and will assume all responsibilities connected with such treatment.

Patient Name _____ Relation to Patient _____
 Signature _____
 (Signature of Parent/Guardian if patient is a minor)