

Patient's Name _____ Date ___/___/___
Birth Date ___/___/___ Age _____ SSN ___/___/___
Marital Status [] Single [] Married [] Divorced [] Widowed [] Separated
Home Address _____
City/State/ZIP _____
Phone (___) ___-____ Mobile Phone (___) ___-____ Work Phone (___) ___-____
Insurance Company _____ ID # _____ Group# _____
E-mail address _____

Employer _____ Occupation _____
Business Address _____ Phone (___) ___-____
City/State/ZIP _____

Spouse/Partner Name _____ Spouse/Partner Employer _____

Person Responsible for Account: _____

Address _____ City/State/ZIP _____

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 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.
❖ We accept: Cash, Check, Discover, MasterCard and VISA (we do not offer the 5% discount on credit/debit cards)
❖ We are partners with CareCredit. Ask us how to apply.

AGREEMENT FOR EXTENSION OF CREDIT

In accordance 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 1-2% per month on the unpaid balance (annual rate of 18%) with a minimum charge of \$.50 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 _____

IF PATIENT IS A MINOR

I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

Signature of Parent or Guardian _____