

## Patient Information

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

Chart #.

FOR OFFICE USE ONLY

Patient Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

Whom may we thank for referring you to our practice?

- |  |   |
|--|---|
| <input type="checkbox"/> Another patient, (friend or relative) | <input type="checkbox"/> Work             |
| <input type="checkbox"/> Internet: Toothmansion.com            | <input type="checkbox"/> Yellow Pages     |
| <input type="checkbox"/> Other Dental Office                   | <input type="checkbox"/> Dental Insurance |
| <input type="checkbox"/> 1-800-DENTIST                         | <input type="checkbox"/> Pankey Institute |
| <input type="checkbox"/> Other (name below):                   |   |

Name of person, office, or other source referring you to our practice:

## Spouse or 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:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  Email Address:

Phone:     Best time to call:   
Home Work Ext Mobile

Address:    
    
City State Zip Code

## Employment Information

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

Employer Name:  Phone:

Address:    
    
City State Zip Code

## Primary Insurance Information

### Primary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

## Secondary Insurance Information

### Secondary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code



2525 South Wadsworth Blvd. #23  
Lakewood CO 80227

(303)985-0909  
happytooth@toothmansion.com

www.toothmansion.com

Mark Granger, D.D.S.

## 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.

The provider may use my health care information and may disclose such information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

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 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 or email me to discuss this statement or my treatment.

We reserve the right to charge a missed appointment fee. This fee is not covered under insurance and will be your responsibility. In order to avoid this charge any necessary cancellations must be made at least 48 hours in advance.

Thank you for understanding our policies. Please let us know if you have any questions or concerns

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

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

Signature: \_\_\_\_\_

Date:

Relationship to Patient:

Response Date: