Lester H. Low, DDS • 3133 W March Lane Ste 1090 • Stockton CA 95219-2336 • Phone (209)474-3333• Fax (209)478-8940• www.SmilesDoctor.com

Patient Information

All information is necessary for our files and will be considered **Confidential**

Patient Name_____Age_____Spouse Name_____
if patient is a minor, then parent or guardian name_____Relationship_____
Residence Address_____City_____State_____Zip_____
Residence Phone_____Work Phone_____ Cellular _____ Pager _____
Social Security _____Date of Birth_____Driver License_____
Preferred method to contact: Home Cell Work Text Email
Occupation_____E Mail Address _____
Employer_____Employer Address_____
City_____State_____ Zip_____
If full time student, name of school_____Grade_____
In case of emergency, who should we contact?_____ Phone_____
Relationship_____
Who may we thank for referring you?_____ Family Friend Phonebook
Former Dentist_____Address_____City_____Phone_____
Reason for visit_____

Primary Insurance / Person responsible for this account

Policy holder_____Relation to patient self spouse parent Guardian
Social Security _____Date of Birth_____
Address(if different from patient)_____City _____State_____ZIP_____
Policy holder's Employer_____Address_____
City_____State_____ZIP_____Phone_____
Insurance Company_____Group #_____
Subscriber #_____ ___Phone#_____
Address_____City_____State_____Zip_____

Additional(Secondary) Insurance

Policy holder_____Relation to patient self spouse parent Guardian
Social Security _____Date of Birth_____
Address(if different from patient)_____City _____State_____ZIP_____
Policy holder's Employer_____Address_____
City_____State_____ZIP_____Phone_____
Insurance Company_____Group #_____
Subscriber #_____ ___Phone#_____
Address_____City_____State_____Zip_____

Medical Insurance Company: Primary Secondary Tertiary

Policy holder_____Relation to patient self spouse parent Guardian
Social Security _____Date of Birth_____
Address(if different from patient)_____City _____State_____ZIP_____
Policy holder's Employer_____Address_____
City_____State_____ZIP_____Phone_____
Insurance Company_____Group #_____
Subscriber #_____ ___Phone#_____
Address_____City_____State_____Zip_____

Please provide all insurance information (insurance booklet, ID cards signed forms) to us.

I certify the information above is true and correct.

Signed_____ Date _____

Continued on other side

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Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends on the reimbursement from the patients for the cost incurred in their care and financial responsibility in the part of each patient must be determined before treatment.
All emergency dental services or any dental service performed without prior financial arrangements must be paid for in cash at the time services are performed. All cosmetic procedures shall be paid in full before treatment begins.

Patents who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he / she is personally responsible for payment of all dental services. This office will help prepare the patients' insurance forms to assist in making collections from the insurance companies and will credit such 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.
A billing charge of 1.5% per month will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me or my relatives, by the doctor or his staff, I agree to pay the reasonable value of said services to said doctor or his assignee at the time said services are rendered or within five(5) days. I further agree that a waiver of any breach of any time or condition hereunder will not constitute a waiver of any further terms or conditions 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 assigns to telephone me at my home or at my work to discuss matters related to this form.
I also agree to a credit check if I request a credit extension by the doctor or his assignees.

I understand that photos or x-rays of me will be taken and may be used for demonstration or educational purposes and give my permission for my likeness to be used in that capacity.
I also declare that all information has been accurate as possible and been completed by my own person.

Preference of Payment

Cash / Check on the day of Treatment
Visa Credit Card Number _____Expires_____
MasterCard Credit Card Number _____Expires_____
Discover Card Credit Card Number _____Expires_____
Care Credit /GE financial Services Signed_____Date_____

If I choose the credit option, I also authorize any remaining balance to be billed to my credit card after verbal authorization (a written confirmation will always be sent to the cardholder).

Consent to treatment **(All must sign)**

I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this form to examine, take x-rays and photos and to administer any treatment or to administer such aesthetics analgesics, sedatives, nitrous oxide sedation, and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics or drugs.
More detailed information will follow for specific procedures at the time of services.
I agree to the above terms printed on front and back of this form.

Signed X_____Date_____

Parent or Guardian_____Relationship to Patient_____

Insurance Assignment of Benefits (all those with insurance must sign)

I authorize this office to bill my insurance company on my behalf for the services rendered to me. I agree to submission of any information regarding this claim to be released to my insurance company. I also authorize the payments to be directly made to this office/dentist for the benefits otherwise payable to me. I understand that I am responsible for all costs of any dental treatment.

Signed X_____Date_____