WARDIUS DENTAL
Cosmetic and Implant Dentistry

Name: _____ Date: _____

Welcome to Wardius Dental! Thank you for selecting our dental healthcare team. Please complete all sections of this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance.

Home Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

How did you hear about us?

☐ Newspaper ☐ Advertisement ☐ Insurance Company

☐ Current Patient, *if so by whom?* _____

Is the patient being treated a Minor? ☐ Yes ☐ No

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you are a student, name of School/ College: _____

City: _____ State: _____

Responsible Party

Name of person responsible for this Account: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Social Security Number: _____ Birth Date: _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured: _____ Relationship: _____

Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Company: _____ Group #: _____

Address of Insurance Co: _____ City: _____ State: _____ Zip: _____

Additional Insurance

Do you have additional insurance? ☐ Yes ☐ No If Yes, complete the following.

Name of Insured: _____ Relationship: _____

Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Company: _____ Group #: _____

Address of Insurance Co: _____ City: _____ State: _____ Zip: _____

Authorization, Release and Agreement to Pay for Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and herby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependants.

X _____ _____

Signature of Patient (or Parent/Guardian if a minor) Date

Financial Arrangement

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions or need special arrangements, please ask for assistance.

Payment in full is due at each appointment.

☐ Cash ☐ Check ☐ Visa ☐ Master Card Card #: _____ Exp. Date: _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for completing this form. The information you have provided will help us serve your dental healthcare needs more effectively. If you have any questions, please ask us.