Falls Family Dental

10450 Durant Road, Suite 102

Raleigh, NC 27614

Patient Information

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

Name (Last) ______________ (First) ______________ (MI) ________

Title: ______ Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other

Date of Birth: __________ Email Address: ____________________

Address: ____

(City) ____________________ (State)________(Zip)__________

Phone: (home) ____________ (work) ____________ (mobile) ____________

Whom may we thank for referring you to our practice? ____________________

Responsible Party Information

Name (Last) ______________ (First) ______________ (MI) ________

Title:______ Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Other

Date of Birth: __________ Email Address: ____________________

Phone: (home) ____________ (work) ____________ (mobile) ____________

Address: ____

(City) ____________________ (State)________ (Zip)__________

Employment Information

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

Employer Name: ______________________ Phone: ____________

Address: ____

(City) ____________________ (State)________ (Zip)__________

Primary Dental Insurance Information

Name of Insured: (Last) ______________________________ (First) ___________________________ (MI) _____

Insured's Birth Date: _________________________ ID# __________________________ Group#: ____________

Insured's Address:____

(City) ____ (State)_____________ (Zip)________________

Insured's Employer Name: ____

Employer's Address: ____

(City) ____ (State)_____________ (Zip)________________

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: ____

Insurance Address: ____

(City) ____ (State)_____________ (Zip)________________

Insurance Contact Phone #: ____

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 cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

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 accept assignment of benefits from most insurance companies, however, the patient is always responsible for any balance their insurance company does not cover.

I understand that any fee estimate for this dental care can only be extended for a period of ninety days from the date of the patient's examination.

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. I further agree to pay all costs and reasonable attorney fees if account goes into collection.

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

Signature: ____ Date: __________________

Relationship to the Patient: ____