Smile Sensations Dental **Welcome To Our Office** (please print / use ink)

Name_____ Date Of Birth_____ Today's Date _____
Last First MI
I prefer to be called: _____

M / F (circle) SS# _ _ _ - _ _ - _ _ _ _ Occupation _____
Employer _____ Bus. Phone _____
Home Address _____
City State Zip
Home Ph. _____ Cell Ph. _____ Email _____

Check One: ____Single ____Married ____Divorced ____Separated ____Widowed
Spouse's Name _____ Spouse's Employer _____
Spouse's Occupation _____Spouse's Bus. Ph. _____
Nearest Relative Not Living With You _____ Ph. _____
In Case Of Emergency Notify _____ Ph. _____
How Did You Hear About Us? (circle all that apply) *Friend, Family, Co-Worker, Insurance website, General Internet Search, Phone Book, Our Mailer, Other* _____

Physician's Name _____ Physician Ph. # _____

Account Information

Person Responsible For This Account_____Relationship_____
Address _____Phone_____
SS# _____ Driver's License # _____State_____
Home Ph. _____ Work Ph. _____In Emergency, notify _____

I hereby accept responsibility for payment of this account. It is incumbent on the patient or Responsible Party to request alternate financial arrangements, if desired, before receiving any treatment, and any differing arrangements from the standard listed below, should be in writing and signed by both parties. Please note we cannot accept post-dated checks. By signing below, unless other written financial arrangements prevail, I am aware that full payment will be due on any outstanding balance of 45 days from each service date of completion regardless of insurance status. "Service completion" is not a requirement if the patient is the party delaying finalization of treatment. After 60 days, said balance will accrue interest at 1.5% per month (18% per year). After the first billing statement, we reserve the right to add a $4 billing service fee to future statements for that balance to offset related direct costs. After the second billing statement for a balance past due, we utilize an Account Management firm and an account management fee of $26 will be applied after appropriate notice by mail. All returned checks will incur a $35 fee. I understand that any fees incurred in the collection of this account, including attorney's fees, will be added to the balance, and will be payable by the responsible party.

Signature of Responsible Party _____Date_____

INSURANCE -- RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

In requesting examination and/or treatment, I authorize the release of all information (including "x-rays") necessary to process my claims. I authorize this office to affix my name to any and all insurance claims. I also authorize payment to be made directly to Kyle Taylor, DDS III, PLLC (d.b.a. Smile Sensations Dental) by my insurance benefits otherwise payable to me, for professional services rendered. **I understand that payment from my insurance company cannot be guaranteed despite any oral representations or reassurances by employees of this practice, and I agree that I am financially responsible for and agree to pay for any charges not covered by insurance.** Payment will be due on any outstanding balance by 45 days from the date of each service, regardless of the status of any insurance claims. In the event that your dental insurance company sends you payment for services rendered by our office and that payment is related to a balance we have on the books, you must turn over any and all monies in a timely fashion. Failure to do so will result in an immediate placement of your account balance with your Account Management Firm. I authorize this office to contact and exchange information with credit agencies regarding any credit extended on my account.

Signature _____ Date _____
Patient, Parent or Legal Guardian