SILVERWOLF
DENTAL

David V. Fischer, DDS

Family & Cosmetic Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

Confidential Patient Information SSN: _____ Date: _____

Name _____ Birth Date _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check appropriate box : Child ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Student Status Full time ___ part time ___ School _____ Driver License _____

Patient Employer _____ Work Phone _____

Spouse's name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Please list someone not living with you we may contact in an emergency _____

Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Email _____ Birth date _____ Cell Phone_____

Employer _____ Work Phone _____ SSN _____

Is this person currently a patient of our office? Yes_____ No _____

For your convenience, we off the following methods of payment. Please check the option you prefer.

Cash _____ Personal Check _____ Debit _____ VISA _____ MasterCard _____ Discover_____

Payment in full is due at time of service.

Insurance Information

Name of subscriber _____ Relationship _____

Birth date _____ SSN _____ Date Employed _____

Name of employer _____ Work Phone _____

Insurance company _____ Group No. _____ Policy No. _____

Address _____ City _____ State _____ Zip_____

I agree to pay all services provided to me or to members of my family by Silver Wolf Dental. I understand that Silver Wolf Dental will seek payment from my insurance company for amounts covered by insurance. I understand, however, that even if my insurance provider fails to pay for the dental service, I am ultimately responsible to pay all amounts in full within 90 days from the date of service. If I fail to pay, I agree to pay a finance charge of 1.5% per month (18% per year) of the unpaid balance. Should collection become necessary, I agree to pay an additional 50% collection fee and all legal fees dealing with collections, with or without suit, including attorney fees and court costs. I understand that I will be charged $60.00 if I cancel a scheduled appointment within 24 hours of that appointment. I further understand that, due to office policy and certain insurance contracts, cancellation fees are non-negotiable and will not be removed from my account. I also understand that Silver Wolf Dental does not accept cancellations by voicemail. Should any conflict arise between this agreement and previous patient forms, the terms of this agreement will supersede.

Signed _____ Date _____