Vanguard Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out ***all*** the information as best as you can. We look forward to working with you in maintaining your dental health.

Name: _____ Today's Date: _____/_____/_____
Last first m. i.

Home phone #: ( ) _____-_____ Business phone #: ( ) _____-_____ ext. _____

Cell/ other phone #: ( ) _____-_____ E-mail: _____

Home Address: _____
Street City State Zip code

Birth date: _____ Soc. Sec. #: _____ - _____ - _____

In case of emergency call: _____ at: ( ) _____-_____

Pharmacy Information: _____

Reason for today's visit?: ☐ Check-up and X-rays ☐ Cleaning ☐ Other:_____

Whom may we thank for referring you? _____

Dental Insurance Company _____Group#:_____

Member Soc. Sec. #: _____ - ____ - _____ Member ID: _____

Person responsible for account: _____ Birth date: _____

Relationship to the patient: _____ Phone #: ( ) _____ - _____

Employer: _____ Occupation: _____

Business Address: _____
Street City State Zip Code

Home Address: _____
☐ (Same as above) Street City State Zip Code

FINANCIAL POLICY

Your full balance is due at the time of treatment unless arrangements have been made. If you are unable to make your full payments at the time of your visit please tell us prior to being seen for your appointment, so that we can discuss your payment options. We accept Visa, MasterCard, American express, personal checks, cash, and dental fee plan (long term payment plan).

Fees:

- **Disappointments –** If you do not show up for your appointment, you will be charged **$50**.
- **Returned Checks –** All returned checks are subject to a **$25** returned check fee.
- **Late Payment charges –**Accounts with balances over 30 days are subject to a late fee monthly finance charge.
- **Collection Costs –** As permitted by law, you agree to pay all court, collection agency, and other collection costs incurred by this dental office in the collection of any amount you owe us.

ACKNOWLEDGE OF RECEIPT OF NOTICE PRIVACY PRACTICE

I, _____ have received a copy of this office's notice of privacy request.

Patient/ Representative Signature _____

**Patient /Representative Declined to sign. Staff Signature _____