Patient's Name ______________________________ Date of Birth ______________

Mailing Address______________________________ [ ]Male [ ]Female

City ____________________ State ______________ Zip Code ______________

Social Security Number ____________________ **How did you hear about us?** ______________

Responsible Party (if other than patient)

Responsible Party______________________________ Relationship ______________

Email Address for Appointment Confirmations ______________________________

Mother's Information: Name ______________________________ Date of Birth ______________

Mailing Address (if different) ______________________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________
May we send you a text? [ ] Y [ ] N

Social Security Number ______________ Employer ______________ Occupation______________
(REQUIRED)

Father's Information: Name ______________________________ Date of Birth ______________

Mailing Address (if different) ______________________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________
May we send you a text? [ ] Y [ ] N

Social Security Number ______________ Employer ______________ Occupation______________
(REQUIRED)

Insurance Information: Insurance Company Name ______________________ Phone ______________

Policy Holder ______________________________ Group ID ______________

Relationship ______________ Social Security Number ______________ Date of Birth ______________

Appointment Policy

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each appointment. Missed appointments add to the cost of dental care when these reserved facilities are left waiting. We require **48 HOUR** advance notice for rescheduling appointments. We reserve the right to charge a fee for a broken or cancelled appointment without **48 HOUR** notice.

Insurance and Financial Policy

Total payment is appreciated at the time of service. We accept Cash, Check,American Express Visa, MasterCard, or Discover. We also offer 12 month interest free financing through Care Credit. We are in network with several PPO plans; however your insurance policy is a contract between you, your employer and the insurance company. We are not part of that contract except to accept the insurance company's fees. In the event we do not receive payment from your insurance company within 90 days of filing a claim with them, the balance will be your responsibility. You are ultimately responsible for any services not paid for by your insurance company. The total investment remains the responsibility of the patient or guarantor. Insurance is a method of payment and not a method of treatment and is designed to assist patients to achieve their various goals for oral health. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Your treatment plan is individually tailored to your dental needs and is not based on your dental insurance benefits and what they may or may not deem as necessary. This office does not use amalgam (silver) fillings. We place only white resin (tooth colored) fillings. This may or may not be covered by your policy. In order to give you an estimate of cost for your needed dental treatment, we will verify your insurance benefits prior to treatment but they will only give us a basic breakdown of benefits. It is your responsibility to know your contract limitations. It is your responsibility to fully understand the coverage and exceptions of your particular policy.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Consent for Dental Treatment

I hereby give Dr. Tristan H. Greenwalt, Dr. Angela L. Greenwalt, and any of the associates of Lady's Island Dental, PC my consent for dental treatment. I have read and fully understand the above stated policies and I agree to abide by them. I grant permission to you or your assignee, to telephone me at any phone number above to discuss matters related to this form and to my dental treatment. By signing this form, I further authorize photos needed and the release of information to my insurance provider.

Signature ______________________________ Date ______________