Affleck Dental
Restoration & Prosthodontics
Michael S. Affleck, D.D.S.

466 N. Main, Suite 100
Clearfield, UT 84015

(801) 782-5010

Part I. Patient Information

Patient Name _____ Birth Date_____
Phone: Home _____ Cell _____ Business _____
Address _____ City _____ State _____ Zip _____
Sex: M____ F____ Patient's Social Security # _____ Marital Status: M _____ S____W____ D_____
Patient's Employer _____ Patient's Occupation _____
Spouse's Name _____ Spouse's Social Security #_____
Person to contact in case of emergency _____
Address _____ Phone # _____ Relationship_____
Email Address _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party_____ Relationship _____
Residence Address _____ City, State _____ Zip_____
Home Phone # _____ Social Security # _____
Employer's Address _____ City, State _____ Zip_____
Business Phone # _____

Part II. Insurance and Address **(Use your insurance identification card)**

Name of insurance company _____ Group Number_____
Address _____ Insurance Co. Tel # _____
Subscriber's Name _____ Subscriber's Social Security # _____
Your relation to subscriber_____ Subscriber Birth date_____
Subscriber's Employer _____ Employer Phone # _____
Is patient covered under more than one Dental Plan?_____

FINANCIAL POLICY: As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare the insurance forms of our patients and assist in making collections from the insurance companies. The patient agrees to assign insurance benefits to be applied to unpaid balances. However, we cannot render service on the assumption that our charges will be paid by an insurance company. For unpaid accounts, a service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed to accounts exceeding sixty days from date of service unless previous written financial arrangements are satisfied. The patient or responsible party agrees to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter. The fee estimates for this dental care can only be extended for a period of six months from the date of patient examination.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES:

By signing below I acknowledge that I have received a copy of this office's Privacy Policies.

CONSENT TO PROCEED: I authorize Dr. Michael S. Affleck and/or such associates or assistants as he may designate to preform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. This may include arrangements and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments and I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. I give permission for your office to submit insurance claims for services rendered.

I understand that the administration of local anesthetic may cause an unwanted reaction or side effects, which may include, but not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness.

Signature _____ Date _____

Print Name Legibly _____