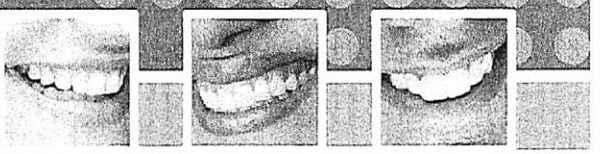
Pediatric Dentistry of New Tampa, Inc.
5326 Primrose Lake Circle
Tampa, FL 33647

(813)374-0388

www.tampahappysmiles.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon

Whom may we thank for referring you to our practice?

☐ Yellow Pages ☐ Internet ☐ Newspaper

☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Social Security Number:

_____

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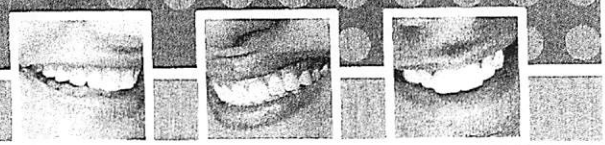

Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

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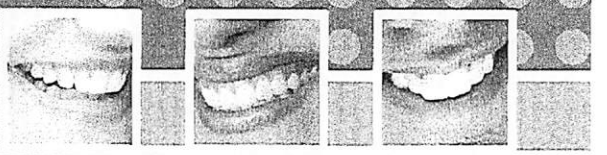

Consent for Services

As a condition of treatment by Pediatric Dentistry of New Tampa, Inc., including the treating dentist(s), financial arrangements must be made in advance. The practice depends upon payment from patients and/or the responsible party for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient or responsible party and that he or she is personally responsible for payment of all dental services regardless of insurance status. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. There will be a charge of $35 for returned checks.

I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all costs and reasonable attorney fees if suit or collection efforts be instituted hereunder. Additionally, I grant permission, unless objected to in writing, for release of patient or responsible party information, including services rendered, necessary for collection efforts of unpaid balances.

I grant permission to you or your assignee, to telephone me to discuss this statement or the treatment provided to my dependent(s) or me.

* ☐ I have read the above conditions of treatment and payment and agree to their content. Additionally, I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature and Relationship to Patient:

Response Date: _____