In-House Dental Care PO BOX 6951 Huntington Beach, CA 92647 Office: (949) 339-5373 Fax: (949) 339-5383

PATIENT AND RESPONSIBLE PARTY INFORMATION

1. PATIENT'S INFORMATION:

Patient's Name: _____ DOB: _____

Residing Address: _____

Phone #: _____ Email: _____

2. RESPONSIBLE PARTY OVER HEALTH DECISIONS: ☐ SELF ☐ Other

(Please attach a copy of the Durable Power of Attorney over Health along with the "New Patient Registration")

Name: _____ Relationship to Pt.: _____

Address: _____

Phone #: _____ Email: _____

3. FINANCIAL RESPONSIBLE PARTY: ☐ SELF ☐ Other ☐ Same person on Line # 2

Name: _____ Relationship to Pt.: _____

Address: _____

Phone #: _____ Email: _____

4. INSURANCE INFORMATION: ☐ NONE

Policy Holder's Name: _____ DOB: _____

Employer's Name: _____ Group # _____

ID # _____

Insurance Company Name: _____ Tel # _____

Mail Claims To: _____

_____

PAYMENT FOR SERVICES RENDERED DISCLOSURE

At In-House Dental Care, we are determined to charge fair and reasonable fees for our unique service. We work on a **fee-for-service** basis and payment is required in advance. We are not a provider of Medical, Medicaid, HMO, or DMO, and we are not contracted with any PPOI plans. If you do have PPO dental insurance, we will file your dental claim on your behalf as a courtesy and have the insurance reimburse you directly.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payments and agree to their contents.

_____ _____

Print Name of Financial Responsible Party Telephone Number

_____ _____

Signature of Financial Responsible Party Date