W O L F
DENTAL
37 Birch Street / Milford, MA 01757
Phone: 508 473 4999
general, cosmetic & implant dentistry for adults
office@wolf.dental
www.davidwolfdds.com

PATIENT INFORMATION

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

Marital Status: _____ Birth Date: _____ Sex: M ☐ F ☐
mm/dd/yyyy

Mailing Address: _____
Street City State Zip Code

Phone Numbers: ( ) _____ ( ) _____ ( ) _____
Home Work Cell

Email: _____

Preferred Contact Method (please select one): Phone ☐ Email ☐ Text ☐

Emergency Contact Person's Name: _____ Phone Number: _____

Whom may we thank for referring you to our practice? _____

DENTAL INSURANCE

Insurance Subscriber's Name: _____ Subscriber's Birth Date: _____

Subscriber's Address: _____
(if different): Street City State Zip Code

Employer's Name: _____ Group #: _____

Insurance Claims Address: _____
Street City State Zip Code

Insurance Phone Number: _____

Is the patient covered by additional dental insurance? If yes, please fill in the info below. Otherwise skip to sign and date.

SECONDARY INSURANCE

Insurance Subscriber's Name: _____ Subscriber's Birth Date: _____

Subscriber's Address: _____
(if different): Street City State Zip Code

Employer's Name: _____ Group #: _____

Insurance Claims Address: _____
Street City State Zip Code

Insurance Phone Number: _____

CONSENT FOR TREATMENT, IMSURANCE PAYMENT AUTHORIZATION AND FINANCIAL POLICY DISCLOSURE

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party or insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered. I understand that estimated co-payments are estimates only, subject to polity maximums, limitations, and coordination of benefit rules. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collection from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-paries or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a fee for appointment missed or cancelled with less than 24 hours of advance notice. This office reserves the right to charge interest of APR = 12% for overdue balances or a billing fee of seventy five cents. In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to the Doctor or his assignee at the time services are rendered or within 15 days of billing if credit is extended. 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 and I agree to pay all costs of collection, including attorney's fees and expenses, incurred to collect any unpaid fees.

Signature _____ Date _____