

STEP 1

LONE PEAK **DENTAL** M. Sean Lorscheider DMD

Welcome to Lone Peak Dental! Please take a moment to fill out this form as complete as you are able. If you have any questions we would be happy to assist you. We look forward to working with you in maintaining your oral health.

PATIENT INFORMATION

If this appointment is for	YOU, please start he	ere:	If this appointment is for your CHILD , please start here:			
Today's Date			Today's Date			
Name		Sex	Name			
Street Address			Street Address			
City	State	Zip Code	City		State	Zip Code
Home Phone #	#	-	Phone # 🗆 Ho	ome or 🗆 Cell	Birthdate	Age
Email Address			School	School Grade		
Driver License# Birtho	date SS#					
Marital Status: 🗆 Single 🗆 M	arried 🗌 Divorce	d 🗌 Widowed				
STEP 2 PRIMA	ARY INSURANCE II	NFORMATION	STEP 3 PERS	ON FINANCIA	LLY RESPONS	IBLE FOR ACCOUNT
Group #	SECONDA 🗌	RY INSURANCE	Name		_	
Dental Insurance Company	Phone #		Address		City	State Zip
Street Address			Home Phone #	Cell Phor	ne # Wo	rk Phone# Ext.
City	State	Zip Code	SS#	i	Driver License	#
Employer	Phone #		Employer Work Address			
Insured Employee Name	Birthdate		Spouse's Nar	ne	Empl	loyer
Date Employed In:	sured Employee S	S #	Work Address		Wa	ork Phone#

STEP 4	GETTING TO KNOW YOU	STEP 5	EMERGENCY	EMERGENCY CONTACT INFORMATION		
Whom may we thank for referring ye	ou to our office?	Emergency Contact Per	son			
What are your hobbies & interests?		Street Address				
Is there anything you'd like to chang	e about your smile?	City	State	Zip Code		
Are any members of your family cur patients of Lone Peak Dental?	rently YES NO	Home Phone #	ne # Work/Cell Phone #			
If yes, what are their names?		Closest living relative t	NOT living with you			
Address		Address				
City State	Zip	Home Phone #	Work/Cell	Phone #		
STEP 6		PLEASE READ - OFFICE F	POLICIES AND TRUTH-I	IN-LENDING STATEMENT		

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (*the amount not covered by insurance*) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of services rendered.

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 of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in consistute a waiver of any further term or condition, and I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees, and commissions (up to 40% of principle) that may be assessed by any collection agency retained to pursue in this matter.

I grant my permission to you or your assignee to call or text me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or the other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. M. Sean Lorscheider.

I certify that I have answered all questions on this form accurately and I hereby agree to abide by the conditions outlined therein.

STEP 7

PLEASE SIGN AND DATE BELOW