OAK MEADOW DENTAL CENTER
FINANCIAL RESPONSIBILITY and CONSENT FOR TREATMENT

Patient Name: _____ Birthday: ___/___/_____
Email (to confirm appointments): _____ Cell (for text reminders): (____)____-_____

Person Responsible for Account:
Name: _____ Relationship to patient: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____)____-_____ Work Phone: (____)____-_____ Cell Phone: (____)____-_____
Occupation: _____ Employer: _____
SS#: ____-___-_____ Driver License#: _____

Nearest Relative/Emergency Contact Name: _____ Phone: (____)____-_____
Address: _____ City: _____ State: ____ Zip: _____

Dental Insurance Information (If you have a card, please hand it to us to copy)
Primary Insurance
Insured Person's Name: _____ Employer: _____
Date of Birth of Insured: ___/____/_____ SS# of Insured: ____-___-_____ Group #: _____
Ins Co Name: _____ Ins Co Phone: (____)____-_____
Ins Co Address: _____ City: _____ State: ____ Zip: _____
Secondary Insurance
Insured Person's Name: _____ Employer: _____
Date of Birth of Insured: ___/____/_____ SS# of Insured: ____-___-_____ Group #: _____
Ins Co Name: _____ Ins Co Phone: (____)____-_____
Ins Co Address: _____ City: _____ State: ____ Zip: _____

Consent:
I consent to treatment as necessary or desirable to the care of the patient named above. I understand that care should be taken after treatment or while in temporaries. Teeth are commonly sensitive for a week or two to temperature after any treatment is performed. Eating food or drinking of hot liquids while numb can cause serious injury. Sometimes decay goes deeper than originally diagnosed or infections can occur that were not originally detected so planned treatment can change or more treatment may be necessary including root canals or extractions. Every attempt is made to color match, even using digital technology similar to photospectometry, but may still vary. I authorized Oak Meadow Dental Center (OMDC) to obtain necessary dental x-rays and records from other dental offices I might have seen in the past or will see in the future. Any disputes that cannot be resolved with the doctors shall be brought to the Santa Clara County Dental Society Peer Review Committee.

I agree to pay my co-pay at the time of service, unless other written arrangements are made with the financial coordinator prior to starting treatment. In the event that my insurance does not pay within 60 days for the treatment performed, I am responsible to pay for said services and I will seek reimbursement from my insurance company. I authorize insurance payment of dental benefits to Oak Meadow Dental Center and the release of medical information necessary to process dental claims. A fee of $28 will be added for bounced checks or accounts sent to collections.

A $55 fee will be charged for missed appointments, including appointments that are cancelled or rescheduled without 48 hours notice. I am responsible for this charge. I also authorize OMDC to call my cell phone number to discuss account and insurance information.

I have read the above and understand it and agree to the terms presented.

Signed (Patient/Parent/Agent): _____ Date: ___/___/_____