

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 photospectrometry, but may still vary. I authorized Oak Meadow Dental Center 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 have read the above and understand it and agree to the terms presented.

Signed (Patient/Parent/Agent): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_