

**JAMES R. SANDLIN, DDS**

Dental Health and Rehabilitation

TODAY'S DATE: \_\_\_/\_\_\_/\_\_\_

PATIENT NAME: MS/MR/MRS \_\_\_\_\_

SEX: M / F      DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_      WHAT MAY WE CALL YOU? \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ WORK PHONE NUMBER: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**ACCOUNT INFORMATION**      *PARTY RESPONSIBLE FOR ACCOUNT:*

NAME: MS/MR/MRS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ WORK PHONE NUMBER: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

*(BALANCES INCURRED FROM THE TREATMENT OF CHILDREN ARE THE RESPONSIBILITY OF THE PARENT REQUESTING CARE.)*

- I WILL BE PAYING IN FULL FOR ALL CARE AT TIME OF TREATMENT
- I WOULD LIKE TO SPEAK WITH SOMEONE ABOUT ASSIGNMENT OF MY DENTAL BENEFITS AND WILL NEED HELP IN FILING MY INSURANCE CLAIM

**WHO MAY WE THANK FOR REFERRING YOU TO US ?**

NAME: MS/MR/MRS: \_\_\_\_\_

**CONSENT TO TREAT:**

I HEREBY AUTHORIZE DR SANDLIN TO TAKE RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDE DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S NEEDS. I ALSO AUTHORIZE DR SANDLIN TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION, AND THERAPY THAT MAY BE INDICATED IN CONNECTION WITH THE TREATMENT OF THE ABOVE NAMED PATIENT. I UNDERSTAND THAT THE USE OF ANESTHETICS AND SOME THERAPEUTIC PROCEDURES EMBODIES CERTAIN RISKS.

I ALSO UNDERSTAND THAT THE RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED BY THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME OF TREATMENT. I FURTHER UNDERSTAND THAT A SERVICE CHARGE EQUAL TO 1.5% OF ANY BALANCE OVER 30 DAYS OLD (18.0% ANNUALLY, MINIMUM CHARGE OF \$5.00 MONTHLY) WILL BE ACCESSED MONTHLY. IN THE EVENT OF DEFAULT, I (WE) PROMISE TO PAY LEGAL INTEREST ON THE DEBT OWED, TOGETHER WITH ANY COLLECTION COSTS, PLUS ATTORNEY FEES EQUALING 15%, AS MAY BE REQUIRED TO COLLECT THIS NOTE.

IN THE EVENT THAT I AM NOT ABLE TO PAY FOR ALL SERVICES AT TIME OF TREATMENT, INCLUDING ASSIGNMENT OF INSURANCE BENEFITS, I AUTHORIZE DR SANDLIN TO REQUEST MY CREDIT INFORMATION FROM EQUIFAX.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE: