

**DENTAL INFORMATION**

Date of last dental treatment?	Last exam and cleaning?
Previous Dentist's name:	May we request x-rays?
Address and Phone:	
How do you feel about your child's teeth?	Do they seem crowded to you?
Do you like the way your child's teeth look?	How often does your child brush?
Do you want your child to keep their teeth?	How often does your child floss?
Do you think your child's teeth are affecting their general health in any way?	

**INSURANCE**

Payment of your percentage of insurance coverage is due at the time of treatment. This amount is only an estimate. However, if there is no payment from your Insurance Company to our office within 60 days from the date of service, you are responsible for the balance in full at that time. We are not able to negotiate with your Insurance Company on your behalf.

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**CASH / CHECK / VISA / MASTERCARD / DISCOVER**  
 Payment is due in full at the time of treatment

**SIGNATURES**

"I CERTIFY THAT THE INFORMATION I HAVE USED TO FILL OUT THESE FORMS IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE DR. GREGORY C. DILGER MY PERMISSION TO EXAMINE, DIAGNOSE, EVALUATE, TAKE NECESSARY XRAYS, CLEAN AND TREAT MY TEETH. I UNDERSTAND THAT THIS PERMISSION MAY BE WITHDRAWN AT ANY TIME. I AGREE TO GIVE 24 HOURS NOTICE OF CANCELLED APPOINTMENTS, FOR WHICH THERE WILL BE NO CHARGE"

I UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO PAY FOR ALL SERVICES RENDERED IN ACCORDANCE WITH THIS POLICY. IF COLLECTION ACTION BECOMES NECESSARY, THE UNDERSIGNED AGREES TO PAY ALL COSTS AND EXPENSES INCURRED. THERE IS A \$45 MISSED APPOINTMENT OR LATE PAYMENT FEE. I HEREBY AUTHORIZE INSURANCE BENEFIT PAYMENT DIRECTLY TO THE ABOVE DENTIST FOR MYSELF AND THOSE LISTED BELOW.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Responsible Party