SILVERWOLF
D·E·N·T·A·L

Dr. Jason Wareham, DMD

Family & Cosmetic Dentistry

New Patient Information

Name: _____ Pref. Name: _____ Birth Date: _____
Cell Phone: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____
Check appropriate box: Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Whom may we thank for referring you? _____
Emergency Contact: _____ Phone _____

Responsible Party

Name: _____ Pref. Name: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____

Insurance Information

Name of subscriber: _____ Relationship: _____
Birth date: _____ SSN: _____ Name of employer: _____
Insurance company _____ Member ID:_____

Payment in full is due at time of service.

I agree to pay all services provided to me or to members of my family by Silverwolf Dental. I understand that Silverwolf Dental will seek payment from my insurance company for amounts covered by insurance. I understand, however, that even if my insurance provider fails to pay for the dental service, I am ultimately responsible to pay all amounts in full within 90 days from the date of service. If I fail to pay within the 90 days, I agree to pay a finance charge of 1.5% per month (18% per year) of the unpaid balance. Should collections become necessary, I agree to pay all collection costs and all legal fees dealing with collections, with or without suit, including attorney fees and court costs. I understand that I will be charged $100.00 if I cancel a scheduled appointment within 24 hours of that appointment. I further understand that, due to office policy and certain insurance contracts, cancellation fees are non-negotiable and will not be removed from my account. Should any conflict arise between this agreement and previous patient forms, the terms of this agreement will supersede.

Signature _____ Date _____