Frances H. Yankie DDS

239 Miller Avenue * Mill Valley California 94941

PATIENT INFORMATION

(This information is necessary for our files and your health and will be considered confidential.)

Name: _____ Birth Date: _____ Spouse's Name: _____

If patient is a minor, give parent or guardian's name: _____

Residence Address: _____ City: _____ Zip: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ Zip: _____

Residence Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail: _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Minor ☐ Children _____

Social Security #: _____

Spouse's Employer: _____ Occupation: _____ Business Phone: _____

Name of nearest relative not living with you: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

All phone numbers: 1) _____ 2) _____ 3) _____

Physician: _____ Address: _____ Phone: _____

Former Dentist: _____ Address: _____ Phone: _____

Purpose of Appointment: _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Preference of payment: ☐ Cash on day of treatment ☐ Mastercard/Visa ☐ Insurance with cash or credit card co-payment

Insurance Company: _____ Policy/Group#: _____ Date Eligible: _____

In whose name is the policy carried: _____ Policy carrier's Social Security #: _____

Birth date of policy carrier: _____

TERMS AND CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for by cash at the time services are performed. For your convenience we also can accept credit cards.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that the patient is personally responsible for payment of all dental services. As a service to the patient, this dental office will help submit the dental claims, assist in making collections from the dental insurance company, and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Every insurance company has several plans which have different internal fee schedules and cover at different rates (i.e. will say that they cover a procedure 100%, but only up to their own internal discounted fee schedule).

In consideration of the professional services rendered to me, or at my request, by Frances H. Yankie-Marsh, D. D. S. or by associates, I agree to pay for the services at the time of service or within five days of billing if credit is extended. I understand that any verbal or written estimates for treatment can only be extended for a period of three months from the date of the patient examination.

This office provides health care by appointment only. Please remember your appointments are reserved specifically for you. If you must change an appointment, we request at least TWO FULL BUSINESS DAYS. A minimum charge of $75.00 will be incurred for missed appointments, or cancelled appointments without sufficient notice.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer any treatment, or to administer such operations as: analgesics, sedatives, nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I promise to ask questions if anything is not fully understood or clear.

Authorization must be signed by the patient, guardian or nearest relative in the case of a minor, or when the patient is physically or mentally incompetent. I have read the above "TERMS AND CONDITIONS" and "CONSENT FOR TREATMENT" and hereby fully agree to their content. I hereby authorize the office of Frances H. Yankie-Marsh, D. D. S. to use the following signature for proof of signature on insurance claim forms.

Signed: _____ Date: _____ Relationship: _____