ROSEWOOD DENTAL
PATIENT INFORMATION

PERSONAL INFORMATION

Patient Name Last First Middle	Sex	Marital Status S M W D SEP	Date of Birth	SS#	Age
Patient Address	City	State	Zip	Phone ( )	
E-Mail Address	Cell Phone ( )		Whom may we thank for referring you?		
Employer	Position	Employer Address	Work Phone ( ) Ext		

RESPONSIBLE PARTY OR AUTHORIZED AGENT INFORMATION

Responsible Party (circle) Patient Father Mother Husband Wife Other	Name		Date of Birth
Address	City	State	Zip	Phone ( )
Employer	Occupation	SS#	
Employer's Address	City	State	Zip	Phone ( ) Ext

ADDITIONAL CONTACTS

Name of Relative (other than living with you)	Relationship	Address	Phone ( )
Friend	Address		Phone ( )

INSURANCE COMPANY (Primary)	**INSURANCE COMPANY (Secondary)**
Employer Name _____	Employer Name _____
Insurance Name _____	Insurance Name _____
Address _____	Address _____
Phone _____ ID # _____	Phone _____ ID# _____
POLICY HOLDER INFORMATION	**POLICY HOLDER INFORMATION**
Policy Holder_____	Policy Holder_____
Relation of Patient to Insured ___ Self __ Spouse___ Child __ Other	Relation of Patient to Insured ___ Self ___ Spouse ___ Child ___ Other
Date of Birth _____	Date of Birth_____
Street _____	Street_____
City/State/Zip _____	City/State/Zip _____
Phone ( ) _____	Phone ( ) _____
SS# _____ Group # _____	SS# _____ Group # _____

AGREEMENT OF EXTENSION OF CREDIT

"In accordance with the Federal Truth In Lending Act, please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the patient, legal guardian, authorized agent or the responsible party agrees to:

1. Pay in full each time services are rendered, or by previous agreement. We accept cash, check, or most major credit cards.
2. Pay 1.75% per month (21% APR) on any unpaid balance over 30 days past due, with a $2.00 minimum.
3. Authorize a credit bureau report to be obtained when deemed necessary.
4. I grant my permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to my treatment or account.
5. Pay a $20.00 fee on all returned checks.
6. You authorize us to contact you by telephone at any telephone, including any cellular, mobile, & other wireless telephone numbers you have or may attain. You authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded /artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

I agree to pay the remaining balance due plus a 40% collection agency fee on my delinquent account if placed with a collection agency. I also agree to pay any court costs and reasonable attorney fees if my account is placed with or without suit.

_____ _____ _____

Signature Date Print Name