

**Andrew T. McCormick, DDS**  
**855 Fountaingrove Parkway**  
**Santa Rosa, CA 95403**  
**Tel: (707) 579-9993**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_ Date: \_\_\_\_\_  
Mr. Mrs. Ms. Dr.  Male  Female

Single  Married  Divorced  Widowed  Separated Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street City Zip

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ How long there? \_\_\_\_\_

Employer Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

\_\_\_\_\_  
Street City Zip

Name of school if full-time student: \_\_\_\_\_

*Where and when are the best times to reach you?*

Morning  Afternoon  Evening  Any Time  M  T  W  TH  Home  Work  Cell

Spouse name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

*Whom may we thank for referring you?*

Dental Office  Yellow Pages  Newspaper  School  Work  Other: \_\_\_\_\_

The following is for:  the patient's spouse  the person responsible for payment.

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Phone (Home) \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell) \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. City Zip

## CONSENT FOR TREATMENT AND OFFICE AGREEMENTS

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my/my dependant's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of anesthetics, sedatives and other medication as necessary. I full understand that using anesthetic agents embodies certain risks.

**Dentistry is a commitment for both the patient and the dental team. The following are a few guidelines , which will clarify and strengthen this commitment:**

### **Consultation:**

I regularly consult with colleagues to make sure that I am doing the best work possible. When I discuss any patient under those circumstances, I withhold any identifying information to insure confidentiality.

### **Appointments/Phone Contact/Reservation Changes:**

By scheduling an appointment, you reserve a specific time with our office. If you need to reschedule our reserved time, will you please do so by giving a 48-hour notice. Giving adequate notice results in avoiding a fee of \$75.00 per hour for the time reserved for you.

During normal business hours, you are welcome to contact us by phone at **707-579-9993**, or after hours at Dr. McCormick's home at **707-829-3907**.

## FINANCIAL ACKNOWLEDGEMENT

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

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. This dental office will not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Following examination, diagnosis and consultation, you will be presented with a definite treatment plan s well as any alternatives and their costs. This is not a contract, as it may be change by either party. But unless additional work or changes become necessary, the work will be completed as specified and for the fee quoted, provided that treatment is started within six month of the date of presentation.

In consideration for the professional services rendered tome, or at my request, by the Doctor, I agree to pay therefore that reasonable value of said services to said Doctor, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, to me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of guarantor of payment/responsible party