Eric Meeker, DDS, PA

228 Ardice Avenue
Eustis, FL 32726

Patient Information

Patient Name _____ Nickname _____ Sex ____ Age _____

Status: ( ) Married ( ) Single ( ) Child ( ) Other DOB _____ SS# _____

Home Address: _____ Home Phone # _____

City _____ State _____ Zip _____ Cell Phone # _____

Mailing Address: _____ Driver's License # _____

(if different) City _____ State _____ Zip _____

Name of Employer _____ Occupation _____

Employer Address _____ Work # _____ Ext _____

City _____ State _____ Zip _____

Emergency Contact _____ Phone # _____ Relationship _____

How did you hear about our office? _____

If the patient is a minor or dependant, complete the following information for the responsible party:

Name _____ Nickname _____ Sex ____ Age _____

Status: ( ) Married ( ) Single ( ) Other DOB _____ SS# _____

Home Address: _____ Home Phone # _____

City _____ State _____ Zip _____ Cell Phone # _____

Mailing Address: _____ Driver's License # _____

(if different) City _____ State _____ Zip _____

Name of Employer _____ Occupation _____

Employer Address _____ Work # _____ Ext _____

City _____ State _____ Zip _____

To the best of my knowledge the information provided in this form is accurate and complete.

_____

Signature of Patient, Parent of Guardian Date

Do you have Dental Insurance? ( ) yes ( ) no

I understand that it is my responsibility to know the terms, limitations and exclusions of my dental plan. I agree that payment of patient porrtio (deductibles + percentage + co-pays) is due at the time services are rendered. I understand and agree that all dental services are provided directly to me/my dependant/minor, and that I am responsible for all charges for dental services and material not paid by my dental plan.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity. To the extent permitted by law. I consent to the use and disclosure of my protected health information to determine liability and to obain re-imbursement for services provided to me/my dependant/minor. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

Signature of Patient, Parent or Guardian Date

-Payment in full is expected at the time services are rendered.
- If you carry dental insurance, payment of your deductible, percentage and co-pay is expected at the time services are rendered. We will allow your insurance company 30 days to process each claim, after which time you are personally responsible for any unpaid balance on your account.
- There is a $30.00 fee for returned checks which is payable only by cash or money order.
- If it becomes necessary to release your account to an outside agency for collecions you will be responsible for any charges incurred by our office in our attempt to collect any unpaid balance, to include but not limited to: collection fee, skip trace fees, attorney fees and court fees. A minimum collection fee of 50% of your unpaid balance will be added to your account.
- Failed appointment without 72 hour notice will be billed as follows:

1st Time--- $35.00 for the first ½ hour, $15.00 for each additional 15 minutes. Patient will have to pay for treatment in full prior to re-scheduling the appointment and prior to scheduling all future appointments.

2nd Time---$35.00 for the first ½ hour,, $15.00 for each additional 15 minutes. Prepaid funds will be applied towards the failed appointment fees and patient will be dismissed from the practice.

- All records and radiographs are the property of the office. There is a minimum fee of $20.00 for the duplication of records and/or radiographs, and a signed consent for release with at least 48 hour notice is required for duplicates/copies to be produced.

I have read the above conditions for treatment and I grant you permission to contact me at home or at work to discuss matters related to these conditions.

_____ _____

Signature of Patient, Parent or Guardian Date