



248 Pleasant Street, Suite 202
Concord, NH 03301
Tel. (603) 228-7878 Fax. (603) 228-7654

Scott C. Doner, DDS

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Any Time Mon Tues Wed Thurs
Address: _____
Street Apartment # City State Zip Code
E-mail address: _____
Name & phone# of medical emergency contact: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Another dental office School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

(The person responsible for payment)

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____ Driver's License # _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following information is for the patient:

Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

The following information is for the person responsible for payment:

Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Consent for Services

(We encourage you to keep a copy of this form for your reference)

I understand that, as a condition of my treatment by this office:

- I must read, understand and sign all registration, health and dental histories and payment agreement forms before treatment can begin.
- Dr. Doner and his staff intend to provide me with the best care possible and they depend upon reimbursement from me for the costs incurred in my care. I agree that my financial responsibility must be determined before he or his staff can provide any treatment to me.
- I should ask for clarification from Dr. Doner or his staff *before treatment begins* if I do not understand or agree with a phase of treatment or a fee. Otherwise, he and his staff will assume that I have agreed to both and treatment will proceed as planned.
- To properly diagnose my dental conditions or concerns, Dr. Doner needs to have three types of x-rays: a panograph (full “smile” view), bitewings (upper and lower molars on the left and right) and full mouth series of x-rays (individual images of all front and back, upper and lower teeth). These x-rays may or may not be covered by my dental plan (if any) depending upon the dates they were previously taken. I can avoid the cost of new x-rays if I provide copies of recent ones taken at my prior dentist’s or specialist’s office.
- I will be responsible to pay in full all emergency dental treatment costs if I have not made previous financial arrangements with this office.
- Any parent requesting **treatment for a minor child** is financially responsible for that treatment. Dr. Doner’s office cannot bill both parents separately or bill a parent who has not signed this form. In addition, an adult must accompany a minor child unless this office has an authorization stating otherwise signed by the custodial parent.
- When I schedule an appointment, I am committing to that date and time and I am responsible for arriving on time for that appointment. This office will make an effort to remind me of my upcoming appointment. If I provide less than 48 hours notice that I need to cancel my appointment, or, if I fail to arrive as planned, I may be charged a “short notice” or “no show” fee of \$50.00 for each ½ hour of scheduled appointment time missed. This fee helps to offset the cost of setting up the treatment room and having staff on standby for my arrival.
- To help keep the cost of dental care as low as possible, Dr. Doner’s office staff does not routinely mail monthly billing statements. If any account balance requires that a billing statement be mailed, the statement will include a \$5.00 billing charge for each bill sent. Any balances over 60-days old will also include a 1.8% monthly interest fee, including those balances involving charges billed to a commercial dental plan. In addition, returned checks will be assessed a \$20.00 service charge.

By signing below, I give my permission to Dr. Doner or anyone he designates, 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 agree to their content.

X _____
Signature of patient, parent or guardian Relationship to Patient
Responsible for this account

Date Signed: _____