Thank you for selecting First Choice Dental Services for your dental healthcare needs. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, feel free to ask – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name: ______________________ Birthdate: __________ Phone: __________

Address: ______________________ City: __________ State: ____ Zip: ________

Email: ______________________ Cell Phone: __________

Whom may we thank for referring you? ______________________

Emergency Contact: ______________________ Relationship: __________ Phone: __________

Responsible Party

Name of Person Responsible for this Account: ______________________ Relationship to Patient: __________

Address, if different: ______________________ SS#/SIN __________

Email: ______________________ Cell Phone: __________

Financial Policy

First Choice Dental Services, a Diamond Dental Services Inc. company, prides itself on providing all dental services at a low fixed rate including our New Patient Special.

FULL PAYMENT IS DUE THE DAY OF TREATMENT. PARTIAL PAYMENT IS DUE UPON THE START OF MAJOR TREATMENT.

As First Choice Dental Services accepts all Major PPO dental insurance policies, if you have insurance that we accept the estimated patient portion will be the amount due.

Payment Options

For your convenience we accept Cash, Check, Debit and credit cards including Visa, MasterCard, Discover and American Express.

We also offer short-term financing options/payment plans and interest may apply. All arrangements must be made in advance and are subject to an approval process.

Patients with Dental Insurance

Dental Insurance plans often have a fixed rate with the office which is often less than the actual fees for a dental service, therefore the Guarantor or Patient is responsible for any services which exceed the insurance's maximum benefit amount or which are not covered services. **You (Patient or Guarantor) are ultimately responsible for all costs incurred regardless of dental insurance coverage.**

Finance Charge and Fees

Balances in excess of days 30 days are subject to a finance charge of $5.00 per month.

Returned checks are subject to a $35 accounting fee. You are also responsible for any bank charges incurred as a result of the returned check.

I agree to the terms stated above.

Patient/Responsible Party Signature: ______________________ Date: __________