



Michigan Center For Advanced Dentistry

Name: _____ Home: () _____

Address: _____ Work: () _____

_____ Cell: () _____

_____ Email: _____

D.O.B. _____ Sex: _____ Emergency Contact: _____

SS# _____ Phone: () _____

Whom may we thank for referring you to our practice: _____

Primary Insurance:

Insured Name: _____ D.O.B. _____

Employer: _____ Group#: _____

Insurance Co: _____ I.D.# _____

Secondary Insurance:

Insured Name: _____ D.O.B. _____

Employer: _____ Group#: _____

Insurance Co: _____ I.D.# _____

Our Financial Policy:

Our practice is committed to providing the best treatment for you. We will gladly discuss your proposed Treatment and answer any questions relating to your treatment. Whenever possible, we will do our best to provide you an estimate detailing your portion which is expected at the time of service. We accept cash, check, Visa, MC, Discover, American Express and CareCredit. Third Party Financing is also available for extensive treatment. Ask any of our team members for additional information.

Our Appointment Commitment:

We understand that your time is very valuable. Our commitment to you is to do our very best to stay on schedule and to complete your treatment in the allotted amount of time.

Your Appointment Commitment:

In return, we ask that you arrive on time for your scheduled appointment. We do not stack or double book appointments. This time has been reserved exclusively for you. We understand that occasionally an appointment is unable to be kept. We ask that you give a 48 hour notice to change or cancel an appointment. If notice is not give, a \$50 per half hour charge will be incurred on your account.

By signing I agree that I have read and understand the policies stated above:

Signature: _____ Date: _____