Donald J. Arima, DDS, PS
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PATIENT INFORMATION

Date _____ ☐ Male ☐ Female

Name _____ DOB _____ Age _____ Social Security # _____

If child, person responsible for account _____ Relationship to patient _____

Home address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Email _____

Employer _____ Occupation _____ Drivers license # _____

Employer address _____ City _____ State _____ Zip _____

Work phone _____ Ext # _____ Best time to reach _____

Emergency contact _____ Address _____ Phone _____

SPOUSE INFORMATION

Name _____ DOB _____ Age _____ Social Security # _____

Home address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Cell _____ Email _____

Employer _____ Occupation _____

Employer address _____ City _____ State _____ Zip _____

Work phone _____ Ext # _____ Best time to reach _____

DENTAL INSURANCE

Primary insurance name _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Group #, plan, policy # _____

Insured's name _____ Relationship to patient _____

Insured's name DOB _____ Insured's Social Security # _____

Insured's employer _____ Insured's employer phone _____

Employer address _____ City _____ State _____ Zip _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentation thereof unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

NOTICE: Do not sign this agreement before you read and agree to the conditions. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purposes of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. 12% Annual Percentage Rate (APR) on accounts over 90 days. Payment at the time of your visit is encouraged and appreciated.

Signature of responsible party _____ Date _____