Patient Name _____ **Date of Birth** _____

Address _____ **Home Phone** _____

City, State & ZIP _____ **Work Phone** _____

Email Address _____ **Cell Number** _____

Height _____ Weight _____ Single _____ Married _____ Male Female

Are you covered by any dental insurance? Yes No Your Social Security#_____

Name of your employer: _____ Group # _____

Name of Spouse (if applicable) _____ Spouse's Work # _____

Spouse's Social Security # _____ Spouse's Date of Birth _____

Spouse's Employer _____

Is spouse covered by other insurance? If so, name of insurance company: _____

Name of closest relative not living with you? _____ Phone number _____

In case of emergency, who should be contacted? _____ Phone number _____

Who recommended this office? _____

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. We are concerned about your dental care and want to ensure you that it is performed in a responsible manner. In order to assist you with the investment in your dental health, we are providing the following payment options from which you may select a plan that best meets your needs. We accept cash, check, Master Card, VISA, Discover, American Express and Care Credit. You may apply for Care Credit in our office or at CareCredit.com. There will be a $25 charge on all returned checks .

Insurance: We understand the value of insurance benefits and will assist you in obtaining your maximum benefit. We will gladly process your insurance claim for you without charge and will also estimate your deductible and the portion that will not be covered by your insurance. All policies have limitations and most do not cover 100% of the fees for dental services. The estimated amount not covered by your insurance is due at the time of your treatment and may be paid by any one of the options listed above. Our estimates are subject to final approval by your insurance company; therefore, the amount due our office is subject to change. It is your responsibility to be familiar with your individual policy, deductible, exclusions, yearly maximum and percentage of coverage.

Truth and Lending Statement: A FINANCE CHARGE of 1 and 1/2% per month (which is an 18% annual percentage rate) will be added 25 days from statement date on any unpaid previous balance aged over 90 days. The FINANCE CHARGE is calculated by applying the rate of 1 and 1/2% to the previous balance after deducting all payments and other credits during the billing cycle. The FINANCE CHARGE so calculated is then included in the new balance. (Disclosure required by the Federal Consumer Credit Act.)

Telephone Consumer Protection Act: You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Failed Appointment Charge Policy: We make every effort to honor all time commitments and request you extend the same courtesy to us. If for some reason you must change an appointment, we would appreciate several days notice. There will absolutely be no charge as long as we receive 24 hours notice. A $25 per half hour charge will be applied for a change in the hygiene schedule and a $65 per half hour charge will be applied for the doctor's schedule, if you fail to honor your scheduled appointment.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

Patient Signature_____ Date _____

FOR PATIENTS WITH INSURANCE:

I authorize release of any information relating to this claim to my insurance company, and I hereby authorize payment directly to David G. Hudson, D.D.S. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

Patient Signature_____ Date _____