2020 S. Parker Rd. Ste. F
Denver, CO 80231
303.752.2777
Fax 303.752.2780
ccdentalexcellence.com

First Name________________________ Last Name____________________________ Middle Initial________
Preferred Name____________________ Address____
City, State, Zip____
Home Phone______________________ Work Phone______________________ Cell Phone________________
Male Female Minor Single Married Domestic Partner
Birth Date____________________________ Social Security #_______________________________________
Employer____ Occupation__________________________________
E-mail Address____
How do you prefer to be contacted? E-mail Phone Text Message
Emergency Contact______________________________________ Phone______________________________

Responsible Party

Name__________________________________ Relationship to Patient______________________
Birth Date________________ Social Security #____________________
Address__________________________________ City,State,Zip____
Employer________________________________

Insurance Information

Name of Insured ____ Relationship to Patient____________________
Insured's Birth Date____________________ Insured's Social Security/ID #__________________________________
Employer____________________________ Insurance Company______________________________________
Secondary Insurance: Insurance Company____

Consent:

I understand that responsibility for payment of medical/dental services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to Name of Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices regarding my dental treatment and/or finances utilizing these forms of communication. I authorize CCDE to discuss treatment, billing, and/or my personal medical information to ______________________, ______________________. I further understand that if I do not cancel my appointment more than 24 hours before the appointment I will be responsible for a cancellation fee of $50.00/hour allotted for my appointment. I further understand that CCDE has the right to hold my credit/debit card as collateral for a scheduled appointment requesting a deposit of 50.00/hour scheduled. I authorize CCDE to draft the amount deposited if I should fail to show for this appointment and/or not given the requested 24 hour notification of my absence/reschedule.

Responsible Party's Signature____ Date____________________________