Charleston Dental Associates
Belinda Cordray, DMD
1875 Savage Road
Charleston, SC 20407

Patient Information

Patient Name: _____ Nickname: _____ Date: _____
Last First MI
Male ____ Female_____ _____Married _____Single _____Child _____Other
Social Security #_____ Birth Date: _____
Phone (Home) _____ (Work) _____ (Cell) _____
Email Address: _____ Driver's License # _____
Address: _____ City/State_____ Zip Code_____

Who may we thank for referring you to our practice_____
Please list family members that are current patients here: _____

Emergency Contact Information
Name:_____Phone #_____Relationship_____

Insurance Information

Insurance Carrier: _____
Place of Employment_____

If insured different from patient:
Subscriber Name: _____ Date of Birth: _____
Social Security #:_____
Patient Relationship to insured: Spouse_____ Child: _____

Consent for Services

I authorize payment directly to Charleston Dental Associates of group insurance benefits otherwise payable to me. I understand that my dental insurance is a contract between me and the insurance carrier and not between the carrier and the dentist, therefore I am still responsible for all dental fees. I understand that I will be charged for all dental treatment and that any payments received from the insurance carrier will be credited to my account._____**Intial**

If your account becomes past due 90 days, there will be a monthly charge of $20.00 on the remaining balance. In the event of default of payment, you agree to any collection costs/ court fees/ and attorney fees. A $30.00 service charge will be added to account for all returned checks due to insufficient funds or stop payment. _____**Initial**

I authorize Charleston Dental Associates to administer medications and perform such diagnostic and therapeutic Procedures as may be necessary for proper dental care. _____**Initial**

I grant the right to the dental office to release my dental/medical histories and treatment to third party payers/ or other health professionals. _____**Initial**

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date**: _____ Relationship to Patient: _____
Signature of patient, parent, or guardian