

Michael F. Tillery DDS PC & Associates  
3410 North High School Road Ste. B  
Indianapolis, IN 46224  
(317)291-8957

TODAY'S DATE \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX: M F

HOME ADDRESS: \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

RESPONSIBLE PARTY'S ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY'S HOME PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

RESPONSIBLE PARTY'S EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

IS THE PATIENT COVERED UNDER DENTAL INSURANCE? Y N

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? CASH CHECK CREDIT CARD FINANCING

I understand that I am financially responsible for the total cost of treatment whether insurance pays or not. I understand that I am responsible to pay any unpaid balances within 30 days of the date of service if my insurance company fails to pay. I understand that I am responsible for paying any interest, collection fees, court costs, and attorney fees if my account is referred to a third party collection agency. I understand that I will be charged and am responsible for paying for any appointments that are not cancelled more than 48 hours prior to the scheduled appointment time. I consent to be treated by Michael F. Tillery DDS, his associates, and staff.

\_\_\_\_\_  
Patient Signature/Responsible Party(if minor)

\_\_\_\_\_  
Date