

Michael F. Tillery D.D.S
3410 North High School Road Ste. B
Indianapolis, IN 46241

Today's date _____

Patient Name: _____ Date of Birth: _____ Sex: M / F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Email: _____

Emergency Contact: _____ Phone # _____

Responsible Party: _____ Relationship to Patient: _____

Responsible Party's Address: _____

Responsible Party's Home Phone: _____ Work Phone: _____

Cell Phone: _____

Responsible Party's Employer: _____

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 24 hours prior to the scheduled appointment time. I consent to be treated by Dr. Michael F. Tillery DDS, his associates, and staff.

Patient Signature/ Responsible Party (if minor)

Date