JED BERMAN, DDS, FAGD

163 City Island Avenue
City Island, New York 10464
(718) 885-1688

First Name ______ MI ______ Last Name ______ Preferred Name ______

Birth Date ______ Social Security Number ______ ☐ Married ☐ Single ☐ Other

Street address (include Apartment Number) ______ City ______ State ______ Zip Code ______

Home Phone #______________Work Phone #____________Cell Phone #________________

E-mail Address____________________________________

Name of Employer ____

Whom may we thank for referring you to our office?______________________________

Who should we contact in case of an emergency?______________________________
Name Telephone#

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time the services are performed. Payment by cash, checks, and credit cards (Master Card and Visa) are accepted.

A service charge of 1½% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

Fee estimates given for any dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to you or your dependents, or at your request, by the Doctor, you agree to pay the fee of those services to the Doctor, at the time services are rendered, or at the agreed upon time if credit shall be extended and arrangements are made in advance. If your account becomes delinquent, a monthly finance charge equivalent to 18.0% per year will be imposed, and you will be responsible for all collection, court and attorney's fees incurred in collection.

I also agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition.

Our practice works hard to try to accommodate the scheduling needs of all of our patients. Because we are dedicated to providing our patients with the best dentistry and service available, it is **NOT** our policy to schedule several patients at the same time. Any time that we reserve for you is reserved exclusively for you. Should a change be necessary, we require a minimum of 2 full business days notice. This permits another patient to receive care in your absence. Without notice, your reserved appointment time will be charged to your account.

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

____ Date: ________________
(Signature)