PATIENT INFORMATION

DATE_____

NAME_____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SS#_____

ADDRESS_____
STREET APT.# CITY STATE ZIP

BIRTHDATE_____TELEPHONE_____
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL

PLACE OF EMPLOYMENT_____ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT-PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED/
IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME# WORK# FAX# E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP#

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME# WORK# FAX# E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. **I understand that I am responsible for all costs of dental treatment.** I herby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License#

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ Yes ☐No

☐ Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)
Card #_____ Exp. Date _____

SERVICE CHARGE

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $5.00 for a balance under $ 1.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

We Require 2 full business days notice to change or cancel our appointment or a $72.00 fee will be charged.
Please note: A courtesy call will be given a da in advance of your appointment, **this is not an opportunity to cancel.**

PATIENT INFORMATION