PATIENT INFORMATION

DATE ________________________

NAME ____ ☐Married ☐Single ☐Minor ☐Male ☐Female
LAST FIRST M

Social Security # ____

Address ____
Street Apt # City State Zip

Birthdate ____________________ Telephone ____
Month Day Year Home Work Cell Email

Name of Employer ______________________________ 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 boxes for parent information
Adults: Complete side labeled Primary Insured
Dual Coverage: Complete both boxes

PRIMARY INSURED/ **If no insurance, complete for responsible party**	**SECONDARY INSURANCE**
Last First M	Last First M
Street City State ZIP	Street City State ZIP
Home Ph. Work Ph. Cell Ph. Email	Home Ph. Work Ph. Cell Ph. Email
Birthdate (Mo/Day/Year) Relationship to Patient	Birthdate (Mo/Day/Year) Relationship to Patient
Employer Dental Ins. Co.	Employer Dental Ins. Co.
SS# Subscriber # Group #	SS# Subscriber # Group #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name________________________________

Address________________________________

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 hereby 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 by any method, including electronic transfer.

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 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__________

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within ____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 _____% per month (or a minimum charge of $_____for a balance under $_____) which is an annual percentage rate of ____% 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 (currently $25 per outstanding account) and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.