

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Preferred Name: _____
 Last First MI

Male Female Single Married Child Other _____ Date of Birth: ____ - ____ - ____

Phone (Mobile): _____ (Home): _____ (Work): _____ ext. _____

Email: _____

Address: _____
 Street Apt.# City State Zip

Whom may we thank for referring you to our practice?
 Dental Office _____ Patient _____
 Friend _____ Other _____

Is the Patient a full-time student? Yes No If Yes, name of school: _____

Person to contact in case of emergency: Relative: _____ Phone: _____
 Friend: _____ Phone: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____ Male Female
 Last First MI

Relationship to Patient: Spouse Parent Other _____ Date of Birth: _____

Phone (Mobile): _____ (Home): _____ (Work): _____ ext. _____

Address: _____
 Street Apt.# City State Zip

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

PATIENT'S PRIMARY DENTAL INSURANCE

Ins. Co. Name: _____
 Address: _____
 Area Code: _____ Phone: _____
 Policy Holder: _____
 First Name MI Last Name
 SS#: ____ - ____ - ____ D.O.B: ____ - ____ - ____
 Employer: _____
 Group #: _____ ID# _____

PATIENT'S SECONDARY DENTAL INSURANCE

Ins. Co. Name: _____
 Address: _____
 Area Code: _____ Phone: _____
 Policy Holder: _____
 First Name MI Last Name
 SS#: ____ - ____ - ____ D.O.B: ____ - ____ - ____
 Employer: _____
 Group #: _____ ID# _____

Consent for Services: I understand that responsibility for payment of all dental services provided in this office for myself or my dependents is mine. I further understand that a finance charge of 1.5% per month, will be added to any unpaid balance exceeding 90 days, unless previously authorized financial arrangements are satisfied. In the case of default of payment, I promise to pay any interest on the balance due, together with any collection costs and reasonable attorneys fees incurred to effect collection of this account or future outstanding accounts. A \$15 service charge will be added for returned checks. I understand that a fee estimate given for dental services can only be extended for a period of six months from the date of the patient examination.

I assign all insurance benefits to the Doctor. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment. I have read the above conditions of treatment and agree to their content.

Patient Signature: _____ Insured Signature: _____ Date: _____
 (Guardian/Parent if Minor)