

PATIENT INFORMATION

Date _____

Name _____ Married Single Minor Male Female

Address _____

Social Security# _____ Email _____

Phone (Cell) _____ (Work) _____ (Home) _____ Birthdate _____

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 blocks for parent information
Dual Coverage? Also complete secondary insured

Adults-Complete primary insured

Primary Insured (If no insurance complete for responsible party)				Secondary Insured			
_____ Last First M				_____ Last First M			
_____ Street City State Zip				_____ Street City State Zip			
_____ Home Work Cell Email				_____ Home Work Cell Email			
_____ Birthday (Mo/Day/Year) Relationship to patient				_____ Birthday (Mo/Day/Year) Relationship to patient			
_____ Employer Dental Ins. Co.				_____ Employer Dental Ins. Co.			
_____ SS# Subscriber# Group#				_____ SS# Subscriber# Group#			

Has any member of your family ever been treated in our office? Yes No Referred to by _____

Person to contact in case of emergency

Name _____

Address _____

City/State/Zip _____

Phone# _____

Method of Payment

Responsible party has 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. _____

I wish to discuss the Dental Office's Financial Policy

Service Charge If I do not pay the entire new balance within 25 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 \$30 for a balance under \$200) 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.

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 medical/dental 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#