PATIENT INFORMATION

NAME _____ ( ) Married ( ) Single ( ) Minor ( ) Male ( ) Female ( ) Unspecified
Last First M

SOCIAL SECURITY # _____-____-_____ PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE: ( ) self ( ) spouse ( ) father ( ) mother

ADDRESS _____

BIRTHDAY _____ TELEPHONE _____ _____ _____ _____
Month Date Year Home Work Cell E-mail

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

INSURANCE INFORMATION

DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME WORK CELL 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 CELL E-MAIL

_____
BIRTHDAY (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INS. CO

_____
SS # SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____
Relationship: _____
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 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 the third party payers and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Have any members of your family ever been treated at 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 _____
( ) 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 and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.