

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ MARRIED \_\_\_ SINGLE \_\_\_ MINOR \_\_\_ MALE \_\_\_ FEMALE \_\_\_

BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

TELEPHONE \_\_\_\_\_  
HOME WORK CELL EMAIL

EMPLOYER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT PATIENT \_\_\_ FATHER \_\_\_ MOTHER \_\_\_ GUARDIAN \_\_\_ SPOUSE \_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURED

SECONDARY INSURED

\_\_\_\_\_ DENTAL INS.CO EMPLOYER \_\_\_\_\_

\_\_\_\_\_ DENTAL INS.CO EMPLOYER \_\_\_\_\_

\_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

\_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

\_\_\_\_\_ INSURANCE ADDRESS \_\_\_\_\_

\_\_\_\_\_ INSURANCE ADDRESS \_\_\_\_\_

SS# \_\_\_\_\_ SUBSCRIBER# \_\_\_\_\_ GROUP# \_\_\_\_\_

SS# \_\_\_\_\_ SUBSCRIBER# \_\_\_\_\_ GROUP# \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP TO PATIENT DOB \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP TO PATIENT DOB \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

NAME \_\_\_\_\_

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

\_\_\_ Yes \_\_\_ No

ADDRESS \_\_\_\_\_

Whom may we thank for referring you to our office?

CITY/STATE/ZIP \_\_\_\_\_

\_\_\_\_\_

TELEPHONE# \_\_\_\_\_

**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)

**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 payees and/or other health professionals.

**SERVICE CHARGE**

If I do not pay the entire new balance within \_\_\_\_\_ days if the monthly billing date, a service charge will be added to the account for the current monthly billing period.

X \_\_\_\_\_  
PATIENT OR RESPONSIBLE PARTY

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.

DATE \_\_\_\_\_ STATE DRIVER'S LICENSE# \_\_\_\_\_

WE RESERVE THE RIGHT TO BILL FOR MISSED OR BROKEN APPOINTMENTS WITH LESS THEN 48 HRS NOTICE.