

PATIENT INFORMATION

(Please Print)

NAME _____ DATE _____
 Last First MI Preferred
 CHECK APPROPRIATE STATUS: MARRIED SINGLE MINOR OTHER SSN _____
 BIRTHDATE ____/____/____ PHONE (H) _____ PHONE (W) _____ E-MAIL _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 EMPLOYER _____ DATE EMPLOYED _____
 EMPL. ADDRESS _____ CITY _____ STATE _____ ZIP _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____
 PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY (Please complete this section only if responsible party is someone other than the patient)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 DRIVER'S LICENSE # _____ BIRTHDATE ____/____/____ HOME PHONE _____ WORK PHONE _____
 EMPLOYER _____ IS THIS PERSON A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 SSN _____ HOME PHONE _____ WORK PHONE _____ BIRTHDATE ____/____/____
 EMPLOYER _____ GROUP # _____ UNION/LOCAL # _____
 EMPL. ADDRESS _____ CITY _____ STATE _____ ZIP _____
 INSURANCE COMPANY _____ INS. CO. PHONE _____

ADDITIONAL INSURANCE? (Please complete this section only if you have secondary insurance)

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 SSN _____ HOME PHONE _____ WORK PHONE _____ BIRTHDATE ____/____/____
 EMPLOYER _____ GROUP # _____ UNION/LOCAL # _____
 EMPL. ADDRESS _____ CITY _____ STATE _____ ZIP _____
 INSURANCE COMPANY _____ INS. CO. PHONE _____

FINANCIAL ARRANGEMENTS

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT. PAYMENT IS DUE IN FULL AT EACH APPOINTMENT.
 PLEASE CHECK THE OPTION WHICH YOU PREFER: CASH PERSONAL CHECK CREDIT CARD

AUTHORIZATION and RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or on behalf of my dependents. A broken appointment fee will be applied if not given 24 hours cancellation notice. Finance charges will accrue on accounts over 30 days.

SIGNATURE OF PATIENT OR PARENT (if minor)

DATE