PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SS# _____ E-mail address _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# Cell #

NAME OF EMPLOYER _____ ADDRESS _____

FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE # CELL#

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE # CELL#

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

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 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 payors and/or other health professionals.

X _____
☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

_____ _____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
☐ Patient ☐ Father (or Husband)
☐ Guardian ☐ Mother (or Wife)

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)

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.