PATIENT INFORMATION

DATE _____

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

ADDRESS _____
STREET APT# CITY STATE ZIP

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

PATIENT INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED /IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				**SECONDARY INSURED**			
LAST	FIRST		N	LAST	FIRST		N
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME#	WORK#	FAX#	E-MAIL#	HOME#	WORK#	FAX#	E-MAIL#
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER			DENTAL INS. CO	EMPLOYER			DENTAL INS. CO
SS$	SUBSCRIBER#		GROUP#	SS$	SUBSCRIBER#		GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

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 Denial 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 histones 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 Io third party payors and/or other health professionals.

Has any member of your family ever been treated in 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 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. the service change will be a periodic rate of 15% per month (or a minimum charge of $3.00 for a balance under $200.00 which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, promise to pay any legal interest of the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of his account or future outstanding accounts.