PATIENT INFORMATION				DATE				
NAME					□ MARRIED □	SINGLE □ MAL	E □ FEMALE	
	LAST	FIRST	M		_			
ADDRESS	STREET	APT#	CITY		STATE		ZIP	
					SS#			
					□ GUARDIAN □ S			
PATIENT INFO	DRMATION			ADULTS – COM	– MAY NEED TO COMPLETI IPLETE PRIMARY INSURED GE? ALSO COMPLETE SECO		RENT INFORMATION	
PRIMARY INS	SURED /IF NO INS	URANCE COMPLETE FOR F	ESPONSIBLE PARTY	SECOND	ARY INSURED			
LAST	FIRS	Γ	N	LAST	FIR	ST	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	LOYER DENTAL INS. CO			EMPLOYER		DENTAL INS. CO		
SS\$	SUBS	SCRIBER#	GROUP#	SS\$	SUI	BSCRIBER#	GROUP#	
PERSON TO CO				Whom r	nay we thank for refe	erring you to our of	lice?	
Outside of Immedia	•			MET	HOD OF PAYMEN	Т		
Name				Respons	sible party currently	has an account with	h this office	
Address City/State/Zip				☐ Yes ☐ No				
Telephone #				☐ Payment in full at each appointment (cash or personal check)				
AUTHORIZATION				☐ Payment in full at each appointment (☐VISA ☐MC ☐OTHER) Card# Exp. Date				
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				☐ I wish to discuss the Dental Office's Financial Policy				
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				SERV	VICE CHARGE			
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?				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.

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

☐ Yes ☐ No