

## PATIENT INFORMATION

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
Last First M  
SOCIAL SECURITY # \_\_\_\_\_ EMAIL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIP  
DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ TELEPHONE \_\_\_\_\_  
HOME WORK MOBILE  
NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_  
PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER

MINOR CHILD- MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS- COMPLETE PRIMARY INSURED

## INSURANCE INFORMATION

PRIMARY INSURED/ RESPONSIBLE PARTY

NAME \_\_\_\_\_ EMAIL \_\_\_\_\_  
Last First M  
TELEPHONE \_\_\_\_\_  
HOME WORK MOBILE  
ADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIP  
NAME OF EMPLOYER \_\_\_\_\_ INS CO. \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ SUBSCRIBER ID \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
GROUP # \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

## 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. 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 and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X \_\_\_\_\_  
Patient or Responsible Party

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 \_\_\_\_\_ 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 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.

Date

State Driver's License #