Patient Name:______________________ Preferred Name: ________________________
Date of Birth:____________________
Sex assigned at birth (F, M, or intersex): How do you identify your gender? (F, M, or other)
Address:____
City: ____________________________ State/Zip Code:____________________________
Home Phone: ____________________ Mobile Phone:_____________________________
Sibling (s): ____

Who can we thank for referring you to our office?
____

Parent/Guardian 1:____
SSN:____________________________ Date of Birth:______________________________
Employer:_______________________ Occupation: ______________________________
Address:____
City: ____________________________ State/Zip Code:____________________________
Home Phone: ____________________ Mobile Phone:_____________________________
Email Address:____

Parent/Guardian 2:____
SSN:____________________________ Date of Birth:______________________________
Employer:_______________________ Occupation: ______________________________
Address:____
City: ____________________________ State/Zip Code:____________________________
Home Phone: ____________________ Mobile Phone:_____________________________
Email Address:____

Emergency Contact
Name: ____
Relationship to Patient: ____
Home Phone: ____________________ Mobile Phone:_____________________________

Primary Insurance Coverage Information:
Insurance Company: ____
Employer:____
Policy Holder:___________________ Group ID: _______________________________
Subscriber ID: __________________ Relationship to Patient: ☐Parent ☐ Self

Secondary Insurance Coverage Information:
Insurance Company: ____
Employer: ____
Policy Holder: ____________________ Group ID: ______________________________
Subscriber ID: ___________________ Relationship to Patient: □Parent □ Self

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Please initial next to each office policy to indicate you have read and understand them.

____ Payment and/or co-payment is required in full at the time services are rendered.

____ At least 48 hours advance notice is required for all appointment changes, failures and cancellations. A $47 office cancellation/failure/change fee is applied for each appointment affected, if hospital cancellation/failure/change the fee is $200.

____ If you have questions regarding your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are aware of your dental plan coverage and limitations.

____ Please be advised the co-payment requested for services rendered is only an estimate based upon information provided by your insurance company. The information given to our office is never a guarantee of payment. **The account holder is responsible for all charges the insurance company does not pay within 45 days of treatment rendered.**

____ Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in the office, including any fees charged directly by that company.

____ Past due accounts (overdue balance of more than 90 days) will be charged 1.5% interest per month until the account is reconciled. Delinquent accounts (overdue balance of more than 90 days) will be transferred to a collection agency or IN State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any part will be the full responsibility of the account holder.

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether paid or unpaid by insurance.** I hereby authorize the use of this signature on all insurance submissions. I, also understand, and agree to abide by the above policies.

Responsible Party Signature: ____
Relationship to Patient: ____
Date: ____