

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST M ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT. # CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER**INSURANCE 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		LAST		FIRST	
		M				M	
STREET		CITY		STREET		CITY	
		STATE				STATE	
		ZIP				ZIP	
HOME		WORK		HOME		WORK	
		CELL				CELL	
		E-MAIL				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 #		SS#		SUBSCRIBER #	
		GROUP #				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, 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 histories 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

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

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

☐ Yes ☐ NoWhom 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 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.