Patient Information

Date: _____

Name: _____ ☐married ☐single ☐minor ☐male ☐female
Last First MI

Social Security #: _____

Address: _____
Street Apt. # City State Zip

Birthdate: _____
month day year

Telephone: home _____ **work** _____ **cell** _____

Email address: _____

Name of Employer: _____ **Address** _____

If full time student, school name: _____ **Grade:** _____

Person responsible for account: ☐parent ☐guardian ☐spouse ☐father ☐mother

Insurance Information

Minor child-may need to complete both blocks for parent info.
Adults- complete primary insured
Dual coverage? Also complete sencondary insd.

Primary Insured-if no insurance complete for responsible party

Last First MI

Street City State Zip

Home Work Cell

Birthdate (mo/day/yr) Relationship to patient

Employer Dental Ins. Co.

SS# Subscriber # Group #

Secondary Insured

Last First MI

Street City State Zip

Home Work Cell

Birthdate (mo/day/yr) Relationship to patient

Employer Dental Ins. Co.

SS# Subscriber # Group #

Emergency Contact

Has any member of your family ever been treated in our office? ☐yes ☐no
Whom may we thank for referring you to our office?_____

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 care professions.

Signature_____ Date_____

Method of Payment

___Payment in full at each appt. (cash/check) with 5% courtesy
___Payment in full at each appt. (___Visa___MC___Other)
Card#_____Exp. Date_____3 digit code_____
___Care Credit Payment
Card#_____
___I wish to discuss the dental office's financial policy

Service Charge – If I do not pay the entire new balance within 60 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 1.59% per month (or a minimum of .50) which is an annual percentage rate of 19% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and attorney fees incurred to collect on this account or future outstanding accounts.