PATIENT INFORMATION

Name _____ Date _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____ Ext. ____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

General Dentist _____ Physician _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY

Who is responsible for the account? Name _____ Relationship _____

Address (if different than patients) _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____ Ext. ____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured _____

Relationship to patient _____
(if different than above)

Insured's Birthdate _____

Identification # _____

Employer _____

Insurance Company _____

Group # _____

Ins. Phone _____

Ins Co. Address _____

_____

Maximum _____ Coverage% _____

Secondary

Name of Insured _____

Relationship to patient _____
(if different than above)

Insured's Birthdate _____

Identification # _____

Employer _____

Insurance Company _____

Group # _____

Ins. Phone _____

Ins Co. Address _____

_____

Maximum _____ Coverage% _____

AUTHORIZATION AND RELEASE

I consent to the dentist's disclosures of my information, which he deems are necessary in connection with my treatment.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to pay the estimated co-pay at the time of service. Any remaining balance due after insurance pays their portion is due within 30 days of receipt.

I agree to pay a service charge reflecting an annual rate of 7% that will be added monthly to any unpaid balance that is not paid within 30 days.

I agree that in the case of default on payment of this account, I will pay all collection costs and reasonable attorney fees incurred in attempting to collect this and any future outstanding account balances.

I realize that failure to keep this account current may result in our office being unable to provide additional dental services.

By signing below you affirm that the above information is accurate, agree to our payment terms, and consent to our disclosures of your information that our office deems necessary in order to provide proper treatment.

X _____

Signature of patient or parent if minor

Date