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