PATIENT INFORMATION

DATE_____

NAME _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ MINOR
LAST FIRST M

ADDRESS _____
STREET CITY STATE ZIP

BIRTH DATE _____ E-MAIL ADDRESS_____
MONTH DAY YEAR

TELEPHONE_____
HOME WORK CELL PHONE

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____
Has any member of your family ever been treated in our office? ☐ YES ☐ NO
Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH BLOCKS FOR MINOR CHILD,
FILL IN APPROPRIATE BLOCK FOR ADULT

FATHER/HUSBAND PATIENT HERE __YES__NO

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO SUBSCRIBER # GROUP #

MOTHER/WIFE PATIENT HERE __YES__NO

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTHDATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD
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 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.

X_____
☐ ADULT PATIENT ☐ FATHER/HUSBAND ☐ GUARDIAN ☐ MOTHER/WIFE

PERSON RESPONSIBLE FOR ACCOUNT

PLEASE CHECK ONE
☐ PATIENT ☐ FATHER/HUSBAND
☐ GUARDIAN ☐ MOTHER/WIFE

METHOD OF PAYMENT

☐ PAYMENT IN FULL AT EACH APPOINTMENT (CASH/CHECK)
☐ PAYMENT IN FULL AT EACH APPOINTMENT (VISA/MC)
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 25 days of the monthly billing date, a service & billing charge will be added to the account for current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% 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.

_____
DATE