Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, ***please fill out this form completely in ink.*** *If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____
Last First M.I.

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Bus. Phone ( ) _____ Cell ( ) _____ Soc. Security _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student ☐ Full Time or ☐ Part Time Email: _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Relationship _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ Social Security # _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check **Credit Card** ☐ VISA ☐ MasterCard ☐ Debit Card ☐ American Express ☐ Discover

I certify that I have read and understand the above information to the best of my knowledge. I understand that I am responsible to pay as services rendered. I understand that I am responsible for any fees that will acquire for legal action being taken to collect my debt. I further understand that if a payment becomes 30 days past due, delinquency at the lesser of the annual rate 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I acknowledge that there is a fee for bounced checks and that I may lose my rights to use checks. Our office is entitled to a minimum of 48 hours cancellation notice. ***We reserve the right to charge cancellation fees for missed or broken appointments.***

_____ _____

Patient Signature Witness Signature

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me, ***I acknowledge that after thirty-days my account may acquire interest. After 45 days if insurance does not pay. I will be responsible for my account.***

_____

Patient Signature

****Over Please****