

WELCOME TO OUR OFFICE

PLEASE PRINT AND **ANSWER ALL QUESTIONS**

Today's Date _____

PATIENT INFORMATION

Patient Name _____ Birthdate ____/____/____
Last First Middle

Address _____ City _____ Zip _____

Hm Ph (____)____-____ Wk Ph (____)____-____ Cell Ph (____)____-____

What is the best way to contact you between 9am and 5 pm? _____

SS# _____ Drivers license # _____ (We will need to make a copy)

Email Address _____

Patient Employer and Address _____

How did you learn of our office? _____

Marital Status Single Widow Divorced Married Spouses Name _____

ACCOUNT INFORMATION (Financial Responsibility) The parent that brings a child to our office is financially responsible.

Name _____ Relationship to patient _____

Birthdate ____/____/____ SS# _____ Drivers License # _____

We must make a copy of your driver's license or photo ID for our records. Your photo may also be taken for our records.

Address _____ City _____ Zip _____

Hm Ph (____)____-____ Wk Ph (____)____-____ Cell Ph (____)____-____

Employer Name and Address _____

DENTAL BENEFIT INFORMATION

Name of subscriber _____ Relationship to patient _____

Benefit Carrier _____ Telephone # _____

Subscriber Birthdate ____/____/____ Group # _____ Contract # _____

AUTHORIZATION FOR DENTAL BENEFITS

I understand that Dr. McKinley's office files dental benefit claim as a courtesy to me. It is my responsibility to notify Dr. McKinley's office immediately of any changes in my dental benefits. I authorize Dr. McKinley to receive all payments directly from my provider otherwise payable to me for services rendered. I understand that I am financially responsible for all fees regardless of the determination and payment of benefits by me dental benefit provider. I agree to make payment in full to Dr. McKinley for any balance outstanding on my account within 10 days.

SIGNATURE _____ DATE _____

FINANCIAL AGREEMENT

I agree to pay for all services in full on the date services are provided unless other financial arrangements have been previously made. I understand that any unpaid balance will be subject to a Late Billing Fee of \$10.00 per month for each month my account remains unpaid. If understand that if it becomes necessary for Dr. McKinley to take collection actions for my unpaid balance, I will be responsible for any and all collection fees, legal fees and court costs. I also agree to pay a \$35.00 processing fee for all returned checks.

SIGNATURE _____ DATE _____

MAKE SURE YOU HAVE SIGNED YOUR FORM

PLEASE COMPLETE THE BACK SIDE OF THIS FORM