Patient Name_____ Date_____

How did you hear about us? _____

PATIENT INFORMATION:

Address_____ City, State, Zip_____

Home phone_____Cell Phone _____ Work Phone_____

Email address _____ Date of Birth____/_____/____ Occupation _____

Employer _____ Address_____

City, State, Zip_____ Social Security #_____/_____/_____

Person who does not live with you – to contact in case of emergency:

Name_____ Relationship_____ Phone_____

ACCOUNT INFORMATION: *(If same as above, write same)*

Person Responsible for payment_____ Relationship to patient _____ Email address_____

Address_____ City, State, Zip_____

Home Phone_____Cell Phone _____ Work Phone_____

Employer _____ Address_____

City, State, Zip_____Occupation_____Social Security #_____/_____/____

PAYMENT OPTIONS

_____ PAYMENT IN FULL AT EACH VISIT (Cash, Check, Credit Card)

_____ PREFER TO DISCUSS OTHER OPTIONS (Including patients who would like us to accept their insurance payments)

I understand that regardless of my insurance status, I am ultimately responsible for the total balance on my account for any professional services rendered. Should my account become delinquent, I agree to pay interest at the rate of 1 1/2% per month (18% annual percentage rate). I also agree to pay all collection costs including attorney fees incurred.

I consent to the use of photographs of my teeth/mouth for educational or marketing purposes.

_____

SIGNATURE

DENTAL INSURANCE INFORMATION:

Insurance Co. #1_____ Group Number _____ Eff. Date ___ / ___ / ____

Address_____ City, State, Zip_____

Policyholder_____ Social Security #_____/_____/_____

Employer_____ Address_____

City, State, Zip_____

Insurance Co. #2_____ Group Number _____ Eff. Date ___ / ___ / ____

Address_____ City, State, Zip_____

Policyholder_____ Social Security #_____/_____/_____

Employer_____ Address_____

City, State, Zip_____

I authorize release of any information necessary to effectively process my claim with my insurance carrier.

_____

SIGNATURE

I authorize payment directly to my attending dentist of the group insurance benefits otherwise payable to me.

_____

SIGNATURE