

DATE _____

PATIENT INFORMATION

NAME _____
LAST FIRST M MARRIED SINGLE MINOR MALE FEMALE

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK #

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 SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

FATHER (OR HUSBAND)				MOTHER (OR WIFE)			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME TELEPHONE #		WORK TELEPHONE #		HOME TELEPHONE #		WORK TELEPHONE #	
BIRTH DATE (MO/DAY/YEAR)		SS #		BIRTH DATE (MO/DAY/YEAR)		SS #	
EMPLOYER				EMPLOYER			
DENTAL INSURANCE CO.		SUBSCRIBER #		DENTAL INSURANCE CO.		SUBSCRIBER #	
GROUP#				GROUP#			

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

Patient Father (Or Husband)

Guardian Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office

YES NO

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (Visa MC)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy

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 payers and/or other health professionals.

SERVICE CHARGE

I agree to pay in full at the time of treatment. However, should any balance remain after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 50%, which will be added to the outstanding balance of my account with or without suit.

X Adult Patient Father (Or Husband) Mother (Or Wife) Guardian

Date _____ State Driver's License # _____