PAGE FAMILY DENTAL

26 Central Ave, Revere, MA, 02151

Family Account Information

Patients' Names: **Date of Birth:** **Gender:**

____ ☐M ☐F
____ ☐M ☐F
____ ☐M ☐F
____ ☐M ☐F
____ ☐M ☐F

Date:___________________
Name of Financially Responsible Person:____
Last First MI
Social Security Number (Required)____________________________________
Date of Birth:_______________
Gender: ☐M ☐F **Family Status**: ☐Married ☐Single ☐ Divorced ☐Other
Address:____
Street City State Zip Code

Phone Numbers May we leave messages regarding treatments, appointments or billing at these numbers?
Home: ________________________ ☐Yes ☐NO
Cell: ________________________ ☐Yes ☐NO Text? ☐Yes ☐NO
Work: _______________ext: _____ ☐Yes ☐NO

I understand that I am responsible for the cost of all dental treatment. I also understand that I am responsible for paying any copayments or deductable that the insurance does not cover. I understand that I will be responsible for any fees if 3rd party collection efforts are required to collect a balance and for any returned check fees. I also understand that there will be a charge for any missed appointments or appointments cancelled with less than 24 hour notice to Page Family Dental.

Signature of Financially Responsible Person:

____**Date:**__________________

Insurance Information
Policy Holder's Name: ______________________________________**Date of Birth:**_________
Last First MI
Subscriber ID#:_______________________________ **Group #:**_________________________
Employer____
Name of Insurance Co.____
I hereby authorize release of any information including diagnosis and records of treatment or examination to my insurance company
Signature:____ **Date:**________________

Family ∞ Care