PATIENT INFORMATION

DATE____________________

NAME ______________________________________ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ MINOR
LAST FIRST M

ADDRESS ____
STREET CITY STATE ZIP

BIRTH DATE ____________________ E-MAIL ADDRESS____________________
MONTH DAY YEAR

TELEPHONE____
HOME WORK CELL PHONE

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 BLOCKS FOR MINOR CHILD,
FILL IN APPROPRIATE BLOCK FOR ADULT

FATHER/HUSBAND PATIENT HERE __YES __NO	MOTHER/WIFE PATIENT HERE __YES __NO
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#	BIRTHDATE (MO/DAY/YEAR) SS#
EMPLOYER	EMPLOYER
DENTAL INSURANCE CO SUBSCRIBER # GROUP #	DENTAL INSURANCE CO SUBSCRIBER# 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/HUSBAND
☐ GUARDIAN ☐ MOTHER/WIFE

METHOD OF PAYMENT

☐ PAYMENT IN FULL AT EACH APPOINTMENT (CASH/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 payors and/or other health professionals.

X____
☐ ADULT PATIENT ☐ FATHER/HUSBAND ☐ GUARDIAN ☐ MOTHER/WIFE

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service & billing charge will be added to the account for current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

____
DATE