

WELCOME TO OUR OFFICE

Date _____

Home Phone _____

Alternate Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last First Middle Initial

Address _____

City _____ State _____ Zip Code _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

AUTHORIZATION

- * I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- * I authorize the dentist to release all information necessary to secure the payment of benefits.
- * I understand that I am financially responsible for all charges whether or not paid by insurance.
- * I understand that any credit granted will be paid in accordance with agreement, and that this office may charge a finance charge of 1 1/2% per month to any balance. In the event of default, collection/attorney fees may apply.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Signature of Patient (Parent/Guardian) _____ Date _____