

PATIENT INFORMATION

Name: _____
(First) (Middle Initial) (Last)

Home Number : _____ Work Number: _____ Cell Phone: _____

Soc. Sec #: _____ Birthdate: _____ Sex: M__ F__

Address: _____ E-Mail: _____

City: _____ State: _____ Zip: _____ Employer _____ Occupation _____

Parent's Name (if child) _____ Phone: _____ Employed By: _____

Spouse's Name: _____ Phone: _____ Employed By: _____

Business Address: _____ Business Phone: _____ Ext: _____

Whom may we thank for referring you? _____ Reason for visit: _____

PRIMARY INSURANCE

Insured Name : _____

Home Phone: _____ Work Phone: _____ Cell Phone/Beeper _____

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

Address (IF DIFFERENT THAN PATIENT'S) _____

Insured Employed By: _____ Occupation _____

Dental Insurance Company: _____

Subscriber I.D.#: _____ Group #: _____

ADDITIONAL INSURANCE

Is patient covered by another Dental Insurance plan: Yes ___ No ___

Subscriber Name: _____ Relationship to Patient _____ Birthdate _____

Soc. Sec # _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address (IF DIFFERENT THAN PATIENT'S) _____

Dental Insurance Company: _____ Subscriber I.D.# _____ Group # _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original)

DATE: _____ SIGNATURE PATIENT OR LEGAL GUARDIAN: _____