DATE_____

PATIENT INFORMATION

WELCOME TO OUR PRACTICE! PLEASE COMPLETE THE FOLLOWING FORM. IF YOU HAVE QUESTIONS OR NEED ASSISTANCE PLEASE LET US KNOW.

HOW DID YOU HEAR ABOUT US? ___ FAMILY ___ FRIEND ___ COUPON ___ PHONE BOOK ___ INS. CO. ___ OTHER

HAS ANYONE IN YOUR FAMILY BEEN SEEN IN OUR OFFICE?_____
NAME

PATIENT NAME_____ M___ F___ CHILD ___ MARRIED ___ SINGLE ___

DOB_____ SS#_____ F/T STUDENT ___Y ___N

ADDRESS_____
STREET (Please inc. even if P.O. Box is used for mail) CITY ST. ZIP

PHONE_____/_____/_____ E-MAIL_____
HOME CELL WORK

RESPONSIBLE PARTY/INSURANCE INFORMATION

NAME_____SS#_____DOB_____

ADDRESS_____
STREET (Inc. even if P.O. Box is used for mail) CITY ST. ZIP

PHONE_____/_____/_____ E-MAIL_____
HOME CELL WORK

EMPLOYER_____DENTAL INS._____

SUBSCRIBER#_____GROUP#_____PHONE#_____

** **EMERGENCY CONTACT**_____
OUTSIDE OF FAMILY HOUSEHOLD ADDRESS PHONE

METHOD OF PAYMENT

_____ Co-pay at time of service w/insurance to be billed. I understand I am responsible for the entire balance should my Insurance Company pay differently than expected. ____initial

_____ PAYMENT IN FULL AT EACH VISIT

_____ I WISH TO DISCUSS FINANCIAL OPTIONS

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of any insurance benefits otherwise payable to me. I give the Dental Office permission to release any information requested to the insurance company or to a specialist on my behalf. I understand that I am financially responsible for all treatment rendered by the Dental Office and that should I choose not to pay, I am responsible for any and all legal expenses incurred to collect this obligation.

X_____
Patient or Resp. Party / Date