PATIENT INFORMATION (CONFIDENTIAL)

NAME____SS#_________________________DATE___________________
FIRST MI LAST
ADDRESS____CITY/STATE_______________________ZIP_____________
HOME PHONE__________________ CELL PHONE__________________ WORK PHONE__________________
BIRTHDATE____________ MINOR SINGLE MARRIED DIVORCED WIDOWED SEX: M F
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER___________________________________
ADDRESS____ CITY/STATE___________________ ZIP_____________
PERSON TO CONTACT IN CASE OF AN EMERGENCY_____________________________ PHONE________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT________________________________ SS#________________
RELATIONSHIP TO PATIENT__________ DRIVER LICENSE#___________________ BIRTHDATE________________
ADDRESS____ CITY/STATE____________________ ZIP_________
EMPLOYER_______________________________ WORK PHONE_______________________

PRIMARY INSURANCE INFORMATION

NAME OF INSURED______________________________ RELATIONSHIP TO PATIENT_______________________
BIRTHDATE____________ SS#________________________
INSURANCE COMPANY____________________________ GROUP______________ ID#________________
ADDRESS_______________________________________ CITY/STATE____________________ ZIP________
PHONE_______________________________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED___________________________ RELATIONSHIP TO PATIENT__________________________
BIRTHDATE______________ SS#________________________
INSURANCE COMPANY_______________________GROUP______________ ID#____________________
ADDRESS__________________________________ CITY/STATE_____________________ ZIP_____________
PHONE ___________________________

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DENTIST OF BENEFITS DUE FOR MY SERVICES RENDERED.

I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I AGREE IF MY ACCOUNT IS NOT PAID IN FULL AT TIME OF SERVICE, I AM LIABLE FOR ANY AND ALL REASONABLE COLLECTION/ATTORNEY FEES IF APPLICABLE. A finance charge of 1-1/2% per month, which is an annual rate of 18% is charged on all past due accounts.

THE PARENT OR GUARDIAN THAT BRINGS IN AND SIGNS FOR A MINOR CHILD IS THE PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

SIGNATURE OF PATIENT OR PARENT/ GUARDIAN IF MINOR DATE

Referral Information

Whom may we thank for referring you to our practice? Another Patient Friend Relative

Dental Office Insurance Newspaper Website Radio Work Other

Dental Office Insurance Newspaper Website Radio Work Other____________________

Name of person or office referring you to our practice:____