

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MALE  FEMALE  
LAST FIRST M

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP

PHONE NUMBERS: \_\_\_\_\_  
HOME CELL WORK

EMAIL (FOR APPOINTMENT CONFIRMATIONS): \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER

**INSURANCE INFORMATION**

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
 ADULTS – COMPLETE PRIMARY INSURED DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY			SECONDARY INSURED		
LAST	FIRST	M	LAST	FIRST	M
ADDRESS – STREET, CITY, STATE, ZIP			ADDRESS – STREET, CITY, STATE, ZIP		
PHONE(S) - HOME, CELL, WORK			PHONE(S) - HOME, CELL, WORK		
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT
EMPLOYER		DENTAL INSURANCE COMPANY	EMPLOYER		DENTAL INSURANCE COMPANY
SSN#	SUBSCRIBER #	GROUP#	SSN#	SUBSCRIBER #	GROUP#

**PERSON TO CONTACT IN CASE OF EMERGENCY**

NAME \_\_\_\_\_

PHONE # \_\_\_\_\_

Has any member of your family ever been treated in our office?  YES  NO

Whom may we thank for referring you to our office?  
 \_\_\_\_\_

**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, photographic 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 by any method, including electronic transfer.

X \_\_\_\_\_  
 Patient or Responsible Party Date

**METHOD OF PAYMENT**

Responsible party currently has an account with this office  
 YES  NO  
 Payment is to be made in full at each appointment via  
 Cash  Personal Check  Credit Card

**SERVICE CHARGE**

If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge of Fifty Dollars (\$50.00) will be applied to last month's balance. In the case of a default 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.