PATIENT INFORMATION

Date_____

NAME_____ ☐Married ☐Single ☐Minor

Last First Int. ☐Male ☐Female

ADDRESS_____

Street Apt. #

_____

City State Zip

HOME PH. #_____ **WORK PH. #**_____EXT._____**CELL PH. #**_____

E-MAIL _____**BIRTHDATE**_____**SS#:**_____

If patient is a full time student, School Name_____Grade_____

Has any member of your family ever been treated in our office? ☐ Yes ☐ No_____

Whom my we thank for referring you to our office?_____

Do you currently have dental insurance? ☐ Yes ☐ No

GUARANTOR/INSURANCE INFORMATION

Primary Insurance

NAME_____**ADDRESS**_____

Last First Int. Street Apt. # City State Zip

HOME PH. #_____ **WORK PH. #**_____**EXT.**_____**BIRTHDATE**_____

EMPLOYER_____**DENTAL INS. CO.**_____

INS. CO. PH. #_____**GROUP #**_____**SS#**_____

Secondary Insurance

NAME_____**ADDRESS**_____

Last First Int. Street Apt. # City State Zip

HOME PH. #_____ **WORK PH. #**_____**EXT.**_____**BIRTHDATE**_____

EMPLOYER_____**DENTAL INS. CO.**_____

INS. CO. PH. #_____**GROUP #**_____**SS#**_____

EMERGENCY CONTACT INFORMATION

NAME_____**PHONE #**_____

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 AND THERAPEUTIC PROCEDUSRES 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 TREATMENTS TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PROFESSIONALS.

DENTAL INSURANCE

I UNDERSTAND THAT THE ESTIMATED PATIENT BALANCE IS DUE AT THE TIME OF TREATMENT. I UNDERSTAND THAT THE TOTAL COST OF DENTAL SERVICES IS ALWAYS THE PATIENT'S RESPONSIBILITY-EVEN WITH VALID DENTAL INSURANCE. I WILL BE CHARGED FOR ALL DENTAL TREATMENT, AND THAT ANY PAYMENTS RECEIVED BY THE DENTAL OFFICE FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ABBOUNT OR REFUNDED TO ME IF I HAVE PAID THE DENTALFEED INSURRED. I ALSO UNDERSTAND THAT A FINANCE CHARGE OF 1.5% PER MONTH (18% PER YEAR) WILL BE ASSESSED FOR ALL UNPAID PATIENT BALANCES. ANY PATIENT BALANCE NOT PAID WITHIN 90 DAYS WILL BE REFERRED TOA COLLECTION AGENCY.

I AM: ☐ Adult Patient ☐ Mother ☐ Father ☐Guardian

Signature_____ **Date**_____