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Welcome!
IN ORDER TO SERVE YOU PROPERLY, WE REQUEST THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

Patient Information:

NAME:______________________________

ADDRESS:____________________ CITY:__________ STATE:______ ZIP:______

SOCIAL SECURITY #:____________________ BIRTHDATE:____________________

HOME PHONE #:____________________ WORK PHONE #:____________________

OTHER PHONE #:____________________ EMAIL ADDRESS:____________________

OCCUPATION:____________________ EMPLOYER:____________________

EMPLOYER'S ADDRESS:____________________ CITY:__________ STATE:______ ZIP:______

PLEASE CHECK: FEMALE MALE OTHER MARITAL STATUS: M S D W

SPOUSE OR PARENT NAME:______________________________

IF STUDENT, NAME OF SCHOOL/COLLEGE:______________________________

WHOM MAY WE THANK FOR REFERRING YOU?______________________________

PERSON TO CONTACT IN CASE OF EMERGENCY:____________________ PHONE:__________

Responsible Party:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:______________________________

RELATIONSHIP TO PATIENT____________________ HOME PHONE #:____________________

ADDRESS OF RESPONSIBLE PARTY:______________________________

EMPLOYER OF RESPONSIBLE PARTY:____________________ WORK PHONE #:____________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? Yes No. DRIVERS LICENSE #: __________

PLEASE READ AND SIGN THE FINANCIAL POLICY AGREEMENT ATTACHED.

Dental Insurance Information:

NAME OF INSURED:____________________ RELATIONSHIP TO PT:__________

BIRTHDATE:____________________ SOCIAL SECURITY #____________________

NAME OF EMPLOYER:____________________ WORK PHONE #:__________

INSURANCE COMPANY:____________________ GROUP #:__________ POLICY/ID #:__________

INSURANCE COMPANY ADDRESS:____________________ PHONE #:__________

HOW MUCH IS YOUR DEDUCTIBLE:____________________ MAXIMUM ANNUAL BENEFIT:____________________

DO YOU HAVE SECONDARY DENTAL INSURANCE? YES NO

I authorize the release of any information, including diagnosis and the records of any treatment or examination rendered to me, my child or ward, during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand and agree that I am responsible for payment of all services rendered on my behalf or my dependents. This authorization shall remain valid and effective for one year from the date of signing.

Date:____________________ Signature:______________________________
(signed)

Relationship to Patient:____________________

FAILED DENTAL APPOINTMENTS CAUSE A WASTE OF VALUABLE PROFESSIONAL TIME AND DEPRIVE OTHERS OF TREATMENT. IF YOU CANNOT KEEP AN APPOINTMENT, YOU MUST NOTIFY OUR OFFICE AT LEAST 24 HOURS IN ADVANCE TO AVOID CANCELLATION OF YOUR APPOINTMENT.