Welcome

Thank you for selecting our office! To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask, we will be happy to help.

Patient Information (CONFIDENTIAL) *Date*_____

Name _____ *Nickname* _____
Home Phone _____ *Cell Phone* _____
Address _____
City _____ *State* _____ *Zip* _____
Social Security # _____ *Birth date*_____
Check Appropriate Box: Single__ Married__ Other__
Email: _____
Patient's Employer _____ *Work Phone*_____
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* _____
Address _____ *Home Phone*_____
Driver's License # _____ *Birth date* _____ *Work Phone* _____
Is this Person Currently a Patient in our Office? Yes No

Dental Insurance Information

Name of Insured _____
Relationship to Patient _____*Birth date*_____ *Social Security #*_____
Name of Employer _____ *Work Phone*_____
Insurance Company _____ *Group #* _____
Insurance. Co. Address _____
City _____ *State* _____ *Zip* _____
DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:
Name of Person Responsible for this Account _____
Relationship to Patient _____*Birth date* _____ *Social Security #* _____
Name of Employer _____ *Work Phone* _____
Insurance Company _____ *Group #* _____
Insurance. Co. Address _____
City _____ *State* _____ *Zip* _____

We are happy to submit any insurance claims on your behalf; however, you are responsible for all costs of dental services received. It is our financial policy that any balance outstanding after 30 days will accrue interest at the rate of 18% per annum. You are also responsible for payment of all costs of collection amounts past due, which may include attorney's fees and collection agency fees. These fees may be up to 50%. THANK YOU!

SIGNATURE OF RESPONSIBLE PARTY _____
SIGNATURE *DATE*