PATIENT INFORMATION (Please Print) Date_____

Name _____ Preferred Name _____ ☐ Male ☐ Female

Last First M

Address _____ Birth Date ____/____/_____

City _____ State _____ Zip Code _____ Present Age _____

Home Phone # _____Work # _____ Ext. _____ Cell # _____

Social Security # _____-_____-_____ Driver's License # _____ State Issued _____

☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Separated E-mail _____

Place of Employment _____ Address _____

If Full Time College Student - School Name, City, State _____

HOW WERE YOU REFERED TO OUR OFFICE? _____

PERSON RESPONSIBLE FOR ACCOUNT

Please check one: ☐ Self ☐ Father ☐ Mother

Name of Person Responsible _____ ☐ Wife ☐ Husband ☐Guardian

DENTAL INSURANCE INFORMATION

* Must include information to process dental claims

Primary Insurance	Secondary Insurance
*Name of Insured Party *Relationship	*Name of Insured Party *Relationship
Home Street Address	Home Street Address
City State Zip	City State Zip
*Social Security Number *Birth Date	*Social Security Number *Birth Date
Home Phone *Work Phone	Home Phone *Work Phone
*Employer *Group #	*Employer *Group #
*Dental Insurance Company	*Dental Insurance Company
*Address for Mailing Claims	*Address for Mailing Claims
*City * State *Zip	City *State *Zip
*Insurance Phone Number	*Insurance Phone Number

METHOD OF PAYMENT

☐ I do not have dental insurance and I agree to pay for any and all treatment IN FULL on the day of service.

☐ I have dental insurance and am responsible for paying my estimated portion on the day services are rendered. I am responsible for calling my insurance company if I have any questions about claims or benefits.

AUTHORIZATION ALL PATIENTS OR GUARDIANS MUST SIGN

I authorize the dentist to perform diagnostic procedures and treatment, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary for proper dental care.
I authorize the use of a third party company to verify my employer's insurance company and insurance plan.
I agree that I am responsible for paying my balance on the day services are rendered.
I am responsible for all legal and business costs related to non-payment of accounts including collection costs.

X_____ _____

Patients or Guardian's Signature Date