DATE__________________

PATIENT INFORMATION

WELCOME TO OUR PRACTICE! PLEASE COMPLETE THE FOLLOWING FORM. IF YOU HAVE QUESTIONS OR NEED ASSISTANCE PLEASE LET US KNOW.

HOW DID YOU HEAR ABOUT US? ____ FAMILY ____ FRIEND ____ COUPON ____ PHONE BOOK
____ INS. CO. ____ OTHER

HAS ANYONE IN YOUR FAMILY BEEN SEEN IN OUR OFFICE?______________________________
NAME

PATIENT NAME____________________________ M___ F___ CHILD ___ MARRIED ___ SINGLE ___

DOB______________________ SS#______________________________ F/T STUDENT ___Y ___N

ADDRESS____
STREET (Please inc. even if P.O. Box is used for mail) CITY ST. ZIP

PHONE________________/________________/________________ E-MAIL______________________
HOME CELL WORK

RESPONSIBLE PARTY/INSURANCE INFORMATION

NAME____SS#________________DOB____________

ADDRESS____
STREET (Inc. even if P.O. Box is used for mail) CITY ST. ZIP

PHONE________________/________________/________________ E-MAIL______________________
HOME CELL WORK

EMPLOYER___________________________________DENTAL INS.___________________________

SUBSCRIBER#________________________GROUP#_________________PHONE#________________

** **EMERGENCY CONTACT**____
OUTSIDE OF FAMILY HOUSEHOLD ADDRESS PHONE

METHOD OF PAYMENT

_____ Co-pay at time of service w/insurance to be billed. I understand I am responsible for the entire balance should my Insurance Company pay differently than expected. ____initial

_____ PAYMENT IN FULL AT EACH VISIT

_____ I WISH TO DISCUSS FINANCIAL OPTIONS

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of any insurance benefits otherwise payable to me. I give the Dental Office permission to release any information requested to the insurance company or to a specialist on my behalf. I understand that I am financially responsible for all treatment rendered by the Dental Office and that should I choose not to pay, I am responsible for any and all legal expenses incurred to collect this obligation.

X ____

Patient or Resp. Party / Date