PATIENT INFORMATION

Full Name____ Nickname____________________
Address_________________________________ City_____________ State______ Zip__________
Home Phone__________ Work Phone__________ May we call you at work?_____ Cell Phone__________
E-Mail Address ____Birth Date_____ Age___ Sex___
Marital Status____________ S.S.#____________________ Occupation______________________
Employer_______________________ Employer Address___________________________________

CHILD INFORMATION

Child's Name______________________________ Nickname_________________________
Sex________ Birth Date_________ Age________ S.S.#___________________________________

PARENT INFORMATION

Full Name____ Nickname____________________
Address_________________________________ City_____________ State______ Zip__________
Home Phone__________ Work Phone__________ May we call you at work?_____ Birth Date_____ Age___
Sex___
Marital Status____________ S.S.#____________________ Occupation______________________
Employer_______________________ Employer Address___________________________________

SPOUSE

Full Name____ Nickname____________________
Sex_____ Birth Date_________ Age________ S.S.#___________________ Work Phone__________
Occupation___________________________ Employer_____________________________________
Employer Address____

RESPONSIBLE PARTY

Who is responsible for payment on this account?___Myself ___My Spouse ___ Other (please complete the following information)
Full Name_________________________ Relationship to patient________________________________
Complete Address____ Phone_____________________
Occupation___________________________ Employer_____________________________________
Employer Address____ Employer Phone_______________

DENTAL INSURANCE

Primary Insurance Information:
Insured's Name________________________________ Insurance Company_____________________
Insurance Company Address____________________________________ Group #________________
Secondary Insurance Information:
Insured's Name________________________________ Insurance Company_____________________
Insurance Company Address____________________________________ Group #________________

In case of emergency who should we notify?___________________________ Phone________________
Whom can we thank for referring you to our office?____

I understand that I am responsible for the payment of dental services provided, regardless of insurance benefits, and that these payments are due at the time services are rendered unless financial arrangements have been made prior to my visit. All overdue accounts are subject to a 1.5% finance charge per month.

Signed: _______________________ Date______