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_____

SPOUSE / PARENT

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_____

DENTAL INSURANCE

Primary Insurance Information:
Employer: _____
Insured's Name_____Birth Date: _____ Insurance Company_____
Insurance Company Address_____
Group #_____ Member # _____

Secondary Insurance Information:
Employer: _____
Insured's Name_____Birth Date: _____ Insurance Company_____
Insurance Company Address_____
Group #_____ Member # _____

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_____