

PATIENT INFORMATION RECORD

DATE: _____

PATIENT INFORMATION:

Name _____

Address _____ City _____ State _____

Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Social Security

Name of parent or guardian if patient is a
minor _____

Is this patient currently enrolled in school or college? Circle: Yes or No

Name of school or college patient attends:

Please list names of family members previously seen in this office

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship _____ Date of Birth _____

S.S.# _____

Address _____ City _____ State _____ Zip
Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____

SPOUSE INFORMATION

Name _____

Employer _____ Work Phone _____ Cell
Phone _____

OTHER

Name of contact person not living with you

Relationship _____

Complete Address _____ Phone _____

Please tell us how you were referred to our office (another patient or doctor, phone
directory, etc.) _____

PAYMENT POLICY

You are responsible to see that your total bill is paid. As a courtesy to you, our patient, we will gladly “estimate” your benefits and file treatment with your insurance carrier. Your insurance co-pay will be collected the day of service. However, please understand that this dental office is not associated with any insurance company and cannot be responsible for benefits that will or will not be paid on your treatment. After 60 days you are responsible for any unpaid balance (even insurance that is pending).

We offer our patients a number of payment options including cash, checks, Mastercard, American Express, Visa and most debit cards. For patients wanting to finance their treatment, we will be glad to put you in contact with a dental finance company, or you may seek financing at your bank.

Patients with insurance will be asked to pay an ESTIMATE of the fee not covered by their insurance the day of treatment. Adjustments, refunds or requests for payment may need to be made after your insurance settles, as any fees quoted are “estimates only.” A finance charge of 1.5% per month will be added to your account on unpaid balances.

DENTAL INSURANCE INFORMATION

Insured’s Name _____ Insured’s Date of Birth _____ Insured’s S.S.# _____

Insured’s

Address _____

_____ Insured’s Employer _____ Insurance

Company _____

Do you have dual coverage? (Please Circle: Yes or No)

Insured’s Name _____ Insured’s Date of Birth _____ Insured’s S.S.# _____

Insured’s

Address _____

_____ Insured’s Employer _____ Insurance

Company _____

ALL THE INFORMATION ON THE FRONT AND BACK OF THIS PAGE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____
