

WELCOME TO OUR OFFICE

Thank you for selecting our dental healthcare team! It is our goal to offer you the best quality dental care possible in a warm, friendly and relaxed environment. Please let us know what we can do to make you feel more comfortable while you are here.

Patient Information

Name _____ Patient No. _____
Address _____ City _____ Zip _____
Phone _____ Date of Birth ____/____/____ SSN _____ - _____ - _____
Please indicate: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated
Spouse's Name _____ Employer _____ Bus. Phone _____
(If a minor) Parent's Name _____ Employer _____ Bus. Phone _____
Emergency contact person _____ Relation _____ Phone _____
Whom may we thank for referring you? _____

Our Financial Policy

Payment for services, including insurance co-payment, is due at the time services are rendered unless alternative arrangements have been approved in advance by our office.

A fee may be incurred for broken appointments and cancellations without 24 hours advance notice.

Returned checks, and balances older than 90 days, may be subject to additional collection fees and interest charges of 1 ½ % per month.

Regardless of any insurance status, the patient or responsible party is ultimately responsible for the balance of the account.

Responsible Party / Insurance Information

Person responsible for this account _____ Relationship _____
Address _____ Date of Birth ____/____/____ SSN _____ - _____ - _____
Name of employer _____ Bus. Phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE ? Y ___ N ___ IF YES, COMPLETE THE FOLLOWING:

Name of insured _____ Date of Birth ____/____/____ SSN _____ - _____ - _____
Name of employer _____ Bus. Phone _____
Ins. Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information. I authorize the release of any information, including photographs, x-rays and records, to be used for the purpose of demonstration, education, publication or insurance documentation. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent if minor _____ *Date* _____