Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____ Birthdate _____

Soc. Sec # _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____ Birthdate _____

Relationship to the patient _____ Driver's License # _____

Soc Sec. # _____

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Work Phone _____ Email _____

Home Phone _____ Cell # _____

3 Telephone

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Cell # _____

4 Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured	Name of Insured
Relationship to patient	Relationship to patient
Insured's birthdate	Insured's birthdate
Soc. Sec. #	Soc. Sec. #
Employer	Employer
ID #	ID #
Ins. Phone #	Ins. Phone #
Insurance Company	Insurance Company
Group #	Group #
Insurance Co. Address	Insurance Co. Address
Deductible	Deductible
Max annual benefit	Max annual benefit

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. 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

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment.

_____ Cash
_____ Personal Check
_____ Credit Card _____Visa _____MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owned will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask. We are always happy to help.