

Welcome

We would like to welcome you and your family to our dental office! We will strive to provide you with the best service possible. To help us meet all your dental healthcare needs, please fill out this entire form. If you have any questions or need assistance, please ask us and we will be happy to help you.

1 Patient Information

Today's Date: _____ / _____ / _____

Name: _____ Wish to be called: _____

Birthdate: _____ / _____ / _____ SS#: _____ - _____ - _____ Male Female Non-binary
 Single Married Minor

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

Work #: _____ Ext: _____ Best time to call: _____

Employer (or School): _____ Occupation (or Grade): _____

Contact person (not living with you): _____

Relationship: _____ Phone #: _____

Whom may we thank for referring you: _____

How would you like to be reminded of your appointment?

Phone: _____ Text: _____ Email: _____

2 Responsible Party

Name (if different than above): _____

Husband Wife Father Mother Guardian

Birthdate: _____ / _____ / _____ SS#: _____ - _____ - _____

Billing Address: _____ Own Rent

City: _____ State: _____ Zip: _____

Home #: _____ Cell/Pager #: _____

Work #: _____ Ext: _____ Best time to call: _____

Employer: _____ Occupation: _____

3 Family Members

Spouse (if married): _____ Relationship: _____
 Other family members: _____

[OVER →]

4 Dental Insurance

Primary Dental Insurance

Insured's Name (Subscriber): _____
 Relationship to patient: _____
 Insured's birthday: ____/____/____
 SS# or ID # _____

Insurance Company (Carrier): _____
 Group #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone# _____

Secondary Dental Insurance

Insured's Name (Subscriber): _____
 Relationship to patient: _____
 Insured's birthday: ____/____/____
 SS# or ID # _____

Insurance Company (Carrier): _____
 Group #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone# _____

5 Authorization

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payors and/or other healthcare 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 my services. I will be responsible for payment of all services rendered on my behalf or my dependents, whether I have insurance or not.

I understand that when I reserve an appointment time, it is important to keep it or give 24 hours notice to cancel, otherwise I may be charged up to \$35 per visit to cover overhead costs.

X _____ /_____/_____
 Signature of Patient **or** Parent of Minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option you prefer:
 Cash
 Personal Check (DL#: _____)
 Credit Card (Visa, MC, Discover)
 I wish to discuss a payment plan prior to any dental treatment

Dental insurance as a rule does not pay for all dental procedures. All balances and patient co-payments are due at time of service unless prior arrangements are made. A late charge of 1.5% per month may be assessed on all unpaid balances.