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
[ ] 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.