

PATIENT INFORMATION

Name: _____ Birth Date: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip code: _____

Please prioritize preference how you would like to be contacted by numbering the following 1, 2, 3, 4 on the left:
 _____ Home Phone: _____ Single () Married () Divorced () Widowed ()

_____ Work Phone: _____ Spouse's Name: _____ And SS#: _____

_____ Mobile Phone: _____ If Child: Parents Name (or custodial parent/guardian): _____

_____ Email Address: _____ Parent Name Not Living In The Home: _____

Employer Name: _____ Employer Address: _____

Occupation: _____ Referred to us by: _____

In Case of an Emergency, Contact (Name, Address, phone): _____ Closest relative not living with you (Name, address, phone): _____

Is another member of your family or relative a patient at our office? If yes their name: _____

PERSON FINANCIALLY RESPONSIBLE

Please fill out this section **only** if person financially responsible is different from the patient

Name/Spouses name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip code: _____

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Social Security Number: _____ Spouse's SS #: _____

IF YOU DO NOT HAVE DENTAL INSURANCE, PLEASE INDICATE WITH AN X ()

DENTAL INSURANCE

PRIMARY DENTAL CARRIER

Subscriber Name: _____ Subscriber ID or Social Security #: _____

Subscribers Birth Date: _____ Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ Group or Local Number: _____

Please fill in employer name, address, phone number and occupation below only if it is different than listed above under patient information.

Employer Name: _____ EmployerAddress: _____

Employers Phone Number: _____ Occupation: _____

SECONDARY DENTAL CARRIER

Subscriber Name: _____ Subscriber ID & Social Security #: _____

Subscribers Birth Date: _____ Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ Group or Local Number: _____

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Occupation: _____

It is the policy of this office to require payment in full when services are rendered. Dental insurance is a contract between the subscriber and the insurance carrier. We are happy to process any insurance forms for you at no charge. Please leave all current insurance information and completed forms with the financial manager. For major treatment, a financial plan can be arranged prior to treatment with our financial manager. A current credit report will be acquired. **A finance charge** of 1.0% on the unpaid balance will be charged on all accounts.

Method of payment: **Cash Payments ()** **Credit Cards ()** **Please Tell Me about Financing Options ()**

Patient or Guardian Signature: _____ Date: _____

