COMPLETION OF THIS FORM IN ITS ENTIRETY IS REQUIRED AT TIME OF VISIT/TREATMENT

PATIENT INFORMATION

Name _____ Social Security # _____- _____- _____
LAST FIRST M.I.

Home Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Birthdate_____Age_____

E-mail Address _____

Employed by _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Spouse/Parent Name _____ Social Security # _____ - _____ - _____

Employed by _____ Birthdate _____

Work Address _____ Phone (_____) _____

In case of emergency:

Relative to contact other than spouse/parent _____

Address _____ Phone (_____) _____

Who referred you to this office? _____ Phone (_____) _____

INSURANCE INFORMATION

Name of Insured_____ Social Security # _____ - _____ - _____

Insurance Co. _____ Address _____ Phone (_____) _____

Policy # _____ Insured Employer _____

Secondary Insurance Information: If you have NO insurance, check here: ☐

Name of Insured_____ Social Security # _____ - _____ - _____

Insurance Co. _____ Address _____ Phone (_____) _____

Policy # _____ Insured Employer _____

FINANCIAL INFORMATION

If someone other than patient is responsible for payment, complete the following:

Name of Responsible Party _____ Social Security # _____- _____ - _____

Address _____ Relationship to Patient _____

Employed by _____ Address _____

Home Phone (_____) _____ Work Phone (_____) _____

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that the doctor can use my records if he so determines.

In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of information by the doctor in scientific papers or demonstrations for educational purposes.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____

If any of the above information changes during the course of your treatment, please notify us immediately!

*There will be a finance charge on account balances over 90 days.