WELCOME TO OUR PRACTICE

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.

PERSONAL INFORMATION

DATE:_____ BIRTHDATE:_____
SOC. SEC#_____
NAME:_____
NAME YOU WISH TO BE CALLED_____
Circle correct answers:
Male / Female Minor Single Married Divorced Widowed Separated

ADDRESS:_____
CITY,STATE,ZIP_____
PHONE #S HOME:_____ WORK#_____
CELL PHONE #_____
EMPLOYER:_____
OCCUPATION:_____
REFERRED BY:_____

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE ACCOUNT?
NAME:_____RELATIONSHIP TO PATIENT:_____
BIRTHDATE:_____ SOC. SEC.#_____
ADDRESS:_____
CITY,STATE,ZIP:_____
EMPLOYER:_____ OCCUPATION:_____
HOME#_____ WORK#_____

IN THE EVENT OF AN EMERGENCY,WHO SHOULD WE CONTACT?
NAME:_____ RELATIONSHIP:_____
HOME#_____ WORK#_____

FINANCIAL ARRANGEMENTS

FOR YOUR CONVENIENCE,WE OFFER THE FOLLOWING METHODS OF PAYMENT:
CASH / CHECK / CREDIT CARD (VISA/ M/C)

PAYMENT IS DUE IN FULL AT EACH APPOINTMENT

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 payors 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.

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 OWED WILL BE ASSESSED EACH MONTH. 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 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.

_____

SIGNATURE OF PATIENT OR PARENT IF MINOR

DATE:_____

******DENTAL INSURANCE INFORMATION******

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____
INSURED'S BIRTHDATE_____ SOC. SEC.#_____

EMPLOYER_____ DATE EMPLOYED_____
OCCUPATION_____

INSURANCE COMPANY_____
GROUP#_____
INSURANCE COMPANY ADDRESS_____
_____
DEDUCTIBLE:_____
MAX . ANNUAL BENEFIT:_____

******SECONDARY DENTAL INSURANCE******

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT_____
INSURED'S BIRTHDATE_____ SOC. SEC.#_____
EMPLOYER_____ DATE EMPLOYED_____
OCCUPATION_____
INSURANCE COMPANY ADDRESS_____