PATIENT INFORMATION

Name_____ Sex _____ Age_____
Last First
Address_____
Street City State Zip
Home Phone_____ Cell Phone_____

Date of Birth _____SS#_____ Email Address_____

Are you a full time student?_____ Name of School_____

Place of Employment_____ Employment Phone_____

Employment Address_____
Street City State Zip

Are you currently on active duty in the Military Service of the United States Government? _____

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR AND/OR IS COVERED UNDER THEIR PARENT'S INSURANCE

Father's Name_____ SS#_____ Date of Birth_____

Address_____
Street City State Zip
Home Phone_____ Cell Phone_____

Employer_____Employer Phone_____

Employer Address_____
Street City State Zip

Mother's Name_____ SS#_____ Date of Birth_____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____

Employer_____ Employer Phone_____

Employer Address_____
Street City State Zip

Family Dentist_____ Phone_____

Referring Dentist_____ Phone_____

Physician_____ Phone_____

Pharmacy Name_____Phone_____

Next of Kin/Emergency Contact_____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Relationship to Patient_____

PATIENT NAME

PRIMARY INSURANCE INFORMATION

Dental Insurance Carrier_____

Address_____
Street City State Zip

Policy/ID#_____Group#_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

Medical Insurance Carrier_____

Address_____
Street City State Zip

Policy/ID#_____Group#_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

SECONDARY INSURANCE INFORMATION

Dental Insurance Carrier_____

Address_____
Street City State Zip

Policy/ID#_____ Group#_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

Medical Insurance Carrier_____

Address_____
Street City State Zip

Policy/ID#_____Group#_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Date of Birth_____ Employer_____

Insurance: To avoid misunderstanding regarding dental and medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees.
Agreement to Pay: I agree to be personally responsible for the payment of all services rendered on my behalf. In the event a quotation of fees is not given to me before the services being performed, I shall ask for such quotation or waive my right to later claim the fee exceeded the value of the services rendered. In the event that payment for dental services is not made within thirty days of treatment, the interest at the legal prevailing rate plus a service charge may be added to the past due balance. If collection measures become necessary, all costs, including legal and/or court costs, will be the responsibility of the patient or guardian.

PATIENT OR GUARDIAN SIGNATURE_____DATE_____

For office use only:
Insurance Sent_____

_____

X-RAYS
Received_____ Returned_____ Predetermination Sent_____