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

PATIENT INFORMATION

Name_____ Social Security #_____

Home Address_____City_____State_____Zip_____

Date of Birth _____ E-mail _____

Home Phone (_____) _____Work (_____) _____Cell (_____) _____

Employed by_____Occupation_____

Work Address_____City_____State_____Zip_____

Spouse/Parent Name_____Social Security #_____

Employed by_____

Work Address_____Phone (_____)_____

In case of emergency:

Relative to contact other than spouse/parent_____

Address_____Phone(_____)_____

Current Physician _____Phone(_____)_____

How were you referred to our office? _____

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

Name of Insured_____Date of Birth_____ID/SSN#_____

Insurance Co._____Address_____Phone(_____)_____

Policy #_____Insured Employer/Address and Phone_____

Secondary Insurance Information: If you have NO insurance check here: □

Insured_____Date of Birth_____ID/SSN#_____

Insurance Co._____Address_____Phone(_____)_____

Policy #_____Insured Employer/Address and Phone_____

FINANCIAL INFORMATION

If someone other than the 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, the undersigned, authorize direct remittance of (surgical, medical, dental) benefits, if any, otherwise payable to me for services rendered. I acknowledge that I am financially responsible whether or not paid by insurance. If it becomes necessary to effect collections of amount, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

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.