WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need any assistance, please ask us - we will be happy to help.

1 Personal Information

Current Date _____ Birthdate _____ SSN _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name _____ Wish to be called _____

Address _____ City _____ State _____ ZIP _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Name _____ Relationship _____

Birthdate _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

3 Telephone

Home Phone _____ Work Phone _____

Home Phone _____ Call Preference: ☐ Home ☐ Work ☐ Mobile

Best Time To Call? Time _____ Day(s) _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Phone _____

4 Insurance Information

Primary Insurance		Secondary Insurance	
Name of Insured		Name of Insured	
Relationship		Relationship	
Insured's Birthdate		Insured's Birthdate	
SSN:		SSN:	
Employer		Employer	
Date Employed		Date Employed	
Occupation		Occupation	
Insurance Company		Insurance Company	
Group#		Group#	
Employee/Cert.#		Employee/Cert.#	
Ins. Co. Address		Ins. Co. Address	
Deductible		Deductible	
Amount Already Used		Amount Already Used	
Max. Annual Benefit		Max. Annual Benefit	

5 Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health care practitioners.

I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

I understand that my 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 dependants.

Signed By _____ Date _____

6 Financial Arrangements

For your convenience, we offer the follwing methods of payment. Please, mark which you prefer.

Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Visa ☐ MC

☐ I wish to discuss dental office's payment policy

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 (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for 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.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Print Form