WELCOME TO OUR OFFICE

Thank you for selecting our dental healthcare team! It is our goal to offer you the best quality dental care possible in a warm, friendly and relaxed environment. Please let us know what we can do to make you feel more comfortable while you are here.

Patient Information

Name ____ Date of Birth ____ /____ /_____
Address ____________________ City ______________ Zip ________ Email _____________________
Phone (____)_________________ Cell phone (____)_________________ SSN ______ - ____ - ______
Please indicate: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated
Spouse's Name _____________________ Employer_____________________ Bus. Phone______________
(If a minor) Parent's Name___________________ Employer _______________ Bus. Phone ____________
Emergency contact person ________________________ Relation _____________ Phone _______________
Whom may we thank for referring you? ____

Our Financial Policy

Payment for services, including insurance co-payment, is due at the time services are rendered unless alternative arrangements have been approved in advance by our office.

Returned checks, and balances older than 90 days, may be subject to additional collection fees and interest charges of 1 ½ % per month.

Regardless of any insurance status, the patient or responsible party is ultimately responsible for the balance of the account.

MISSED APPOINTMENTS: ***A fee may be incurred*** for broken/missed appointments and cancellations without 24 hours advance notice.

Responsible Party / Insurance Information

Person responsible for this account ____ Relationship __________________
Address ____ Date of Birth ____ / ____ / ____ SSN _____ - ____ - ______
Name of employer ____ Bus. Phone ________________________
Address of employer _______________________________ City __________________ State ________ Zip ____________
Insurance Company _________________________________Group # _______________ Union or Local # ______________
Ins. Co. Address ____________________________________ City __________________ State ______ Zip ___________

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE ? Y ___N ___ IF YES, COMPLETE THE FOLLOWING:

Name of insured ___________________________________ Date of Birth ____ / ____/ _____ SSN _____ - ____- _____
Name of employer ____ Bus. Phone ________________________
Insurance Company _________________________________ Group # ______________ Union or Local # _____________
Ins. Co. Address ____________________________________ City __________________ State ______ Zip ___________

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information. I authorize the release of any information, including photographs, x-rays and records, to be used for the purpose of demonstration, education, publication or insurance documentation. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*____

Signature of patient or parent if minor *Date*