We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? ____

Patient Information

Patient's Name Last________________ First________________ Middle____________

Address Street________________________ City____________ State________ Zip________

Cell Phone (for text-msg appt confirmation) (______) ________________ Alt. Phone (______) ________________

Email address ________________________________ Social Security # _______-______-_______

Birthdate ______/______/______ If patient is a minor, give parent's/guardian's name________________________

Emergency contact ________________________________ Phone (______) ________________

Responsible Party Information

Name Last________________ First________________ Middle____________ Marital Status________

Residence Street________________________ City____________ State________ Zip________

Mailing address ________ Street________________ City____________ State________ Zip________

Cell Phone (______) ______________ Alt. Phone (______) ______________ Social Security # ______-_____-______

Birthdate ______/______/______ Relationship to patient ________________________________

Employer ________________________________ Occupation ________________________________

Employer Address ____

Insurance Company ________________________________ Group# ________________________

Insurance Company Address ________________________________ Phone (______) ________________

Secondary Insurance Information

If you have dual coverage, please fill out the following:

Spouse's Name ____ Phone (______) ________________

Social Security # ______-_____-______ Birthdate ______/______/______ Relationship to patient ________________

Employer ________________________________ Occupation ________________________________

Employer Address ____

Insurance Company ________________________________ Group# ________________________

Insurance Company Address ________________________________ Phone (______) ________________

Payment Responsibility

*For our patients without dental insurance……*I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

*For our patients with dental insurance……*I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of <u>all</u> dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office. If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all collection costs.

I understand that it is my responsibility to advise your office of any changes in the information on this form.

Patient ____ Date ________________

Parent or Responsible Party ________________________________ Relationship to Patient ________________