PATIENT INFORMATION

Title: (Mr., Mrs., Ms.) First Name_____ Middle Initial_____ Last Name_____

Sex: ☐ Male ☐ Female •Date of Birth_____ Age_____ Social Security #_____

Street_____ City_____ State_____ Zip_____

Home Tel. # _____ Business Tel. #_____ Ext._____ Cell Phone #_____

Student: ☐ Full Time ☐ Part Time ☐ Not •School Name/Address_____

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single •Spouse name_____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not •Employer _____ Tel. # _____

Street_____ City_____ State_____ Zip_____

Who will be responsible for your account? Relation: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ _____

Name _____ Social Security # _____ Home Tel. # _____

Street_____ City_____ State_____ Zip_____

Employer _____ Tel. # _____

Street_____ City_____ State_____ Zip_____

Home & Address of the Nearest Relative Not Living with Responsible Party:

Name_____ Tel. #_____

Street_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Employee Name _____

Employee Date of Birth _____ • Sex: ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company Name: _____

Address_____ Phone #_____

Group # _____ S.S.#_____

Employer _____ Bus.Phone# _____

SECONDARY DENTAL INSURANCE

Employee Name _____

Employee Date of Birth _____ •Sex: ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company Name_____

Address _____ Phone # _____

Group # _____ S.S.#_____

Employer _____ Bus.Phone#_____

FEES AND PAYMENTS

TO ALL OUR PATIENTS:
We make every effort to keep down the costs of your oral care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late fees, filing fees, court costs and attorney fees. These costs are the patient's responsibility.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this dentist named of the benefits otherwise payable to me.

_____ _____

Patient Signature or Guardian **Date**