

PATIENT INFORMATION

Name _____ Married Single Male Female
 LAST FIRST MI

Address _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell _____

Employer _____ E-mail Address _____

Person Responsible for Payment: Patient Guardian Spouse Father Mother

Whom May We Thank For Referring You To Our Practice _____

EMERGENCY CONTACT (Outside of Immediate Household)

Name _____ Relationship _____

Address _____ Phone # _____

INSURANCE INFORMATION

Name _____ Birthdate _____

Address _____ SS# _____

Home Phone _____ Work Phone _____

Employer _____ Relationship to Patient _____

Dental Ins Co. _____ Group # _____

Insurance will be filed as a courtesy on your behalf; the ultimate responsibility of payment is that of the insured.

DEFAULT PROVISION

If the undersigned does not pay the entire balance within ten (10) days of the billing date, interest shall accrue from said time on any amount then due and owing at the rate of eighteen percent (18%) per annum until paid. Should the undersigned default under these terms, and this account is referred to an attorney for collection, then the undersigned promises and agrees to pay all collection costs including attorney fees of 33 1/3% of the principal amount due and owing when turned over for collection.

AUTHORIZATION

I hereby authorize payment directly to the dental office of the benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer medications and perform such diagnostic, photographic, and therapeutic procedures that may be necessary for proper dental care. The information on this page and the medical/dental history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payors and/or other health professionals. I consent and agree to the use, reproduction or otherwise published photograph of me in any publication or lecture presentation of the doctor. The doctor or any other person authorized by the doctor has the right to use such images in any advertising and promotion of such publication and the dispositions of all rights thereto.

Patient/Responsible Party _____ Date _____

STATE DRIVERS LICENSE # _____