Glenn Family Dental

Excellence in Family and Cosmetic Dentistry

19731 S. Highway 213
Oregon City, OR 97045
Phone: 503-518-3384
Fax: 503-518-3386

Patient Information

Date: ______________

Name: ____ ☐ married ☐ single ☐ minor ☐ male ☐ female
Last First MI

Social Security #: ______________________

Address: ____
Street Apt. # City State Zip

Birthdate: ______________
month day year

Telephone: home __________________ **work** __________________ **cell** __________________

Email address: ________________________

Name of Employer: ________________________ **Address** ______________________________

Whom may we thank for referring you to our office? ______________________________

Person responsible for account: ☐ parent ☐ guardian ☐ spouse ☐ father ☐ mother ☐ self

Insurance Information

Minor child-may need to complete both blanks for parent info.
Adults - complete primary insured
Dual coverage? Also complete secondary insd.

Primary Insured-if no insurance complete for responsible party	Secondary Insured
Last First MI	Last First MI
Street City State Zip	Street City State Zip
Home Work Cell	Home Work Cell
Birthdate (mo/day/yr) Relationship to patient	Birthdate (mo/day/yr) Relationship to patient
Employer Dental Ins. Co.	Employer Dental Ins. Co.
SS# Subscriber# Group#	SS# Subscriber# Group#

Emergency Contact

Name ________________________

Address ________________________

City/State/Zip ________________________

Telephone # ________________________

Authorization

I hereby authorize payment directly to the dental office of the group insurance 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 such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

Signature: ____________________ **Date:** __________

Financial Policy

If you have dental insurance, we will be glad to assist you in obtaining the maximum benefits specified in your contract. All non-covered fees and deductibles are required to be paid at each visit. Cash, check, bank cards and alternate financing plans are accepted. There is no finance charge on current accounts. After 30 days, all accounts are subject to a finance charge of 1.5% of the unpaid balance (or minimum charge of $1.00) which is an annual percentage rate of 18%. There will be a $25 minimum and up to a $100 maximum charge for any broken appointment without 24 hour notice. In the case of default of payment, I agree to pay any legal interest, together with any reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature: ____________________ ***Date:*** __________