1. About You

Today's Date:_____/_____/ 20____

Name:_____ Preferred Name:_____

Birthdate: _____/_____/_____+ ____ Male _____ Female

SS#: _____ - _____ - _____

Home Address_____

_____

Home #: _____ Cell # _____

Work #:_____Ext: _____

Email Address:_____

Employer:_____Occupation:_____

Where & when are the best times to reach you?_____

How did you learn about our office?_____

Previous/Present Dentist:_____ Last Visit Date ____/_____/__

2. Spouse Information

His/Her Name:_____

Employer:_ _____

Wk # _____ SS #:_____

Birthdate:_____

Person Responsible for Account_____

Wk # _____ SS #:_____

Billing Address:_____

Relationship:_____

Employer:

3. Dental Insurance

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #:_____

Group, ID, Policy #'s_____

Insured's Name:_ _____

Insured's Birthday:_____

Insured's SS #_____

Insured's Employer:_____

Secondary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #:_____

Group, ID, Policy #'s_____

Insured's Name:_ _____

Insured's Birthday:_____

Insured's SS #_____

Insured's Employer:_____

Dr's. McDonald and Gruchalla, DDS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

SIGNATURE **DATE**

Financial Policy

Payment is due at time of service unless prior arrangements have been approved.

• 5% discount on services paid by cash or check at time of service.

• 3% discount on services paid by Visa, MasterCard or Discover at time of service.

• Care Credit Card – Interest free payment option.

I assign directly to Dr's. McDonald and Gruchalla all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. **I am responsible for knowing my insurance benefits and yearly maximum amounts as stated in my insurance contract.** I hereby authorize Dr's. McDonald and Gruchalla to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I have read the above Financial Policy and agree to adhere