About You

Today's Date: _____

Name: _____

I prefer to be called: _____

Birth date: _____/_____/_____ Male Female

SS#: _____ - _____ - _____

Home Address_____

City: _____ State: _____ Zip: _____

Home #: _____ Cell # _____

Work #:_____Ext: _____ Preferred # Home Work Cell

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 _____

Spouse Information

His/Her Name: _____

Employer: _____

Work # _____ SS #:_____ - _____ - _____

Birth date: _____

Person Responsible for Account_____

Work # _____ SS #:_____ - _____ - _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Dental Insurance

Primary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone #:_____

Group #:_____, ID#_____

Insured's Name: _____

Insured's Birth date: _____ SS #:_____ - _____ - _____

Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone #:_____

Group #:_____, ID#_____

Insured's Name: _____

Insured's Birth date: _____ SS #:_____ - _____ - _____

Insured's Employer: _____

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 of Discover at time of service
- Care Credit Card- Interest free payment option

I assign directly to McDonald & Gruchalla, DDS, PC 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-payments or deductibles 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 McDonald & Gruchalla, DDS, PC 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 to it regarding my financial obligation for services rendered.

_____ _____

Signature **Date**

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**