PATIENT INFORMATION

DATE ______________

NAME ______________ LAST FIRST M ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

ADDRESS ______________ STREET APT. # CITY STATE ZIP

BIRTH DATE ______________ MONTH DAY YEAR TELEPHONE ______________ HOME # WORK #

PLACE OF EMPLOYMENT ______________ SS# ______________

IF FULL TIME STUDENT, SCHOOL NAME ______________ GRADE ______________

DENTAL INSURANCE CO. ______________ GROUP # ______________

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

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

FAMILY INFORMATION

FATHER (OR HUSBAND)				*MOTHER (OR WIFE)*			
LAST	FIRST		M	LAST	FIRST		M
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME TELEPHONE #	WORK TELEPHONE #			HOME TELEPHONE #	WORK TELEPHONE #		
BIRTH DATE (MO/DAY/YEAR)	SS#			BIRTH DATE (MO/DAY/YEAR)	SS#		
EMPLOYER				EMPLOYER			
DENTAL INSURANCE CO.			GROUP #	DENTAL INSURANCE CO.			GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

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 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 professionals.

X ______________

☐ Adult Patient ☐ Father (Or Husband) ☐ Mother (Or Wife) ☐ Guardian

______________ Date ______________ State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

☐ Patient ☐ Father (or Husband)

☐ Guardian ☐ Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office

☐ YES ☐ NO

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC)

Card # ______________ Exp. Date ______________

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.