WELCOME TO OUR DENTAL PRACTICE

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us.

PATIENT INFORMATION

NAME_____ REFERRED BY_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SS NO_____ DOB_____ SEX_____

HOME PHONE_____ WORK_____ CELL_____

RESPONSIBLE PARTY

NAME_____ RELATION TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SS NO_____ DOB_____

HOME PHONE_____ WORK_____ CELL_____

PRIMARY DENTAL INSURANCE

SUBSCRIBER NAME_____ RELATION TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SS NO_____ DOB_____ EMPLOYER_____

INSURANCE CO_____ GROUP NO_____

SECONDARY DENTAL INSURANCE

SUBSCRIBER NAME_____ RELATION TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SS NO_____ DOB_____ EMPLOYER_____

INSURANCE CO_____ GROUP NO_____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash _____ Personal Check _____ Credit Card ___VISA ___MC

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

x_____

Signature of patient or parent if minor Date

Thank you for filling out this form completely.
The information you have provided will help us serve your dental healthcare needs more effectively and efficiently.
If you have any questions at anytime, please ask - we are always happy to help.