PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Cell/other phone_____

Email Address_____ _____

Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

In case of Emergency, call:_____ Telephone: _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____

Spouse's Name_____ Relationship to Patient _____

Employer_____

Social Security #_____ Birthdate _____Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ ID#._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ ID# _____

Insurance Co. Address_____ Phone No. _____

METHOD OF PAYMENT

☐ NO INSURANCE
Payment in full at each appointment

☐ INSURANCE
Pt portion to be paid at each appointment

Billing. To avoid a charge please give 48 HOURS notice if you are unable to keep your appointment. Statements will be printed on our last working day of the month.

DELINQUENCY CHARGE. If I do not pay the entire New Balance within 90 days of the monthly billing date a DELINQUENCY CHARGE will be added to the account for the current monthly billing period. The DELINQUENCY CHARGE will be a periodic rate of 1.5% per month or a minimum charge of $1.00 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 on this account.

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. I agree to the use of local anesthesia or inhalation sedation (nitrous oxide, "laughing gas") depending on the judgement of the doctor. I understand that the use of medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of coordination.

The information on this page and the medical history are correct to the best of my knowledge.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____