Patient Information

Patient _____
Name First MI Last

Date of Birth: _____

If child:
Mother's name _____
First MI Last
Father's name _____
First MI Last
Name of Spouse (if applicable) _____

Address _____

City _____ State _____ Zip____

Home Phone _____
Cell Phone _____
Work Phone _____

Someone to notify in case of emergency – Name and phone number

_____

Responsible Party

If new account, who is to be the account holder/ responsible party? _____
Account holder's social security # _____
Account holder's drivers license # _____

Cancellation Policy

Dental visits typically take longer than other medical appointments. For the above reason, we ask for your understanding in notifying us at least 48 business hours ahead of your appointment time if you need to reschedule. If not, we do reserve the right to charge for cancelled appointments if we receive less than 24 hours notice.

Assignment and Release

I consent to dental treatment and authorize release of all information necessary to secure payment of benefits. I authorize my insurance company to lease payment directly to your office for services rendered. The information on this form is correct to my knowledge.

Today's Date _____

How do you wish to be addressed? _____
How did you find out about us? _____

Married/Single/Divorced/Widowed/Other (circle one)

Employer (if applicable) _____
Spouse Employer _____

Patient Social Security No. _____

E-mail address: _____

Dental Insurance (1st coverage)

Policyholder name_____
Policyholder Date of Birth _____
Policyholder Social Sec. /ID No. _____
Employer _____
Name of Insurance Co. _____
Group No. _____

Dental Insurance (2nd coverage, if applicable)

Policyholder name_____
Policyholder Date of Birth _____
Policyholder Social Sec. /ID No. _____
Employer _____
Name of Insurance Co. _____
Group No. _____

Financial Policy

All fees that are the patient's responsibility are due on the day of service. Please keep in mind that insurance is a contract between you and your insurance company, and has no direct relationship with our office. As a courtesy we will submit your claim to your insurance. Our cost estimates are based on very limited information about your plan and additional funds may be due. You are responsible to know and understand your benefit coverage, restrictions, maximums, limitations and exclusions. We can not make any guarantee of insurance payment and you are responsible for any charges insurance does not pay.

Patient **OR** Guardian Signature_____
Date _____