Today's Date_____ Preferred Name_____

Thank you for choosing our healthcare team. It is our goal to provide you with quality dental care. To aid us in meeting your dental needs, please fill out this form completely. If you have any questions, please ask us, we will be happy to help.

PATIENT INFORMATION

Patient Is: _____ Policy Holder _____ Responsible Party _____ Full Time Student ___Male ___Female
Name_____Home Phone #
Address_____ Cell Phone #_____
City_____ State_____ Zip Code _____
Birth date _____ SS#_____
Email Address (we do not send spam) _____

RESPONSIBLE PARTY (if someone other than the patient)

Name _____ Birth Date _____
Address _____ Home Phone #_____
City _____ State_____ Zip Code _____ SS#_____
Employer _____ Work Phone_____ Cell Phone _____
Email Address (we do not send spam) _____

EMERGENCY CONTACT (not spouse)

Name_____ Relationship_____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Birth date _____ SS# or Identification Number _____
Employer_____
Insurance Carrier _____ Phone # _____
Group # _____ Insurance Company Address _____

If you have additional insurance please complete the following:

Name of Insured _____ Relationship to Patient _____
Birth date _____ SS# or Identification Number _____
Employer_____
Insurance Carrier _____ Phone # _____
Group # _____ Insurance Company Address _____

WHO MAY WE THANK FOR REFERRING YOU?_____

Briefly state what your expectations are for excellent dental care _____
_____

I state here that the preceding information is correct. I understand that payment is due as services are rendered unless other arrangements have been made in advance and that my portion of insurance filed is due at the time of service. I authorize my insurance company to pay directly to the dentist and 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 for my dependents. I also understand that I am responsible for all collection charges including attorney fees, court costs and interest charges.

_____ Signature of Patient (parent if minor) _____ Date