PATIENT ACCOUNT INFORMATION

Legal Name: ______________________________ Nickname: ______________

Mailing Address: ____

City: ____________________ State: __________ Zip Code: ____________

Home Phone #: ______________ Business Phone #: ______________ Email Address: ______________

Date of Birth: ______________ Sex: M or F Marital Status: S M D W Spouse's Name: ______________

Social Security # (Required for all patients) ______________ Driver's License #: ______________

IF STUDENT OR CHILD:

Name of School or College: ______________________________ Age: __________

Father's Name: ______________________ Mother's Name: ______________________

APPOINTMENT PREFERENCES:

Day of Week: ____________ Time of Day: __________ Do you wish a reminder call, if possible? Yes or No

Call me at this number: ______________ How did you hear about our office? ______________

Closest Relative not living with patient: ______________________ Relationship: ______________

Address: ______________________________ Phone #: ______________

FAMILY PAYMENT INFORMATION

Person Responsible for paying this account: ______________________________

Mailing Address: ____

City: ____________________ State: __________ Zip Code: ____________

Home Phone #: ______________ Business Phone #: ______________ Email Address: ______________

Date of Birth: ____________ Social Security #: (Required) ______________ Driver's License #: __________

Employer: ______________________________ Section: ______________

Address: ____

Relationship to this patient: Self ______ Spouse ______ Child ______ Other(specify) __________

How do you expect to pay for today's visit? Cash____ Check ____ Credit Card: MC Visa DISCOVER

Other persons covered by this account:

	Name	Date of Birth	Relationship to Responsible Party	School/Employer
1.				
2.				
3.				
4.				

PAYMENT – Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 2% per month (equivalent to 24% PER ANNUM), will be added to the unpaid balance of all accounts over 60 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses including all court costs and reasonable attorney's fees. A minimum charge will be made for failed or cancelled appointments without prior notification of at least 48 hours.

SIGNATURE ____ Date __________

(Patient or Guardian, if patient is a Minor)

IF COVERED BY DENTAL INSURANCE COMPLETE THE REVERSE SIDE

DENTAL INSURANCE INFORMATION

Name of Person (Employee) with Dental Insurance Coverage: ______________________

Address: ______________________ City __________ State ______ Zip Code ________

Date of Birth: ____________ *Social Security #: ______________ Employee's Insurance ID#: ________

Employer's Name: ______________________ Dept/Section: ______________

Employer's Address: ______________________ City __________ State ______ Zip Code ________

Dental Insurance Company's Name: ______________________

Address: ______________________ City __________ State ______ Zip Code ________

Phone #: ______________ Group Number: ____________ Union Local ____________

Annual Deductible: $_______ Annual Maximum Coverage: $_______ Have you seen any other dentists this year? YES or NO

Do you have a completed insurance form as required? YES____ NO ____

* We cannot submit to your insurance without the employee's social security #

Other Persons covered by this insurance plan:

	NAME	Relationship to Employee	Insurance ID#	Social Security #	School/Employer
1.					
2.					
3.					
4.					

2nd DENTAL INSURANCE INFORMATION

Name of Person (Employee) with Dental Insurance Coverage: ______________________

Address: ______________________ City __________ State ______ Zip Code ________

Date of Birth: ____________ *Social Security #: ______________ Employee's Insurance ID#: ________

Employer's Name: ______________________ Dept/Section: ______________

Employer's Address: ______________________ City __________ State ______ Zip Code ________

Dental Insurance Company's Name: ______________________

Address: ______________________ City __________ State ______ Zip Code ________

Phone #: ______________ Group Number: ____________ Union Local ____________

Annual Deductible: $_______ Annual Maximum Coverage: $_______ Have you seen any other dentists this year? YES or NO

Do you have a completed insurance form as required? YES____ NO ____

* We cannot submit to your insurance without the employee's social security #

Other Persons covered by this insurance plan:

	NAME	Relationship to Employee	Insurance ID#	Social Security #	School/Employer
1.					
2.					
3.					
4.					

INSURANCE- For your convenience, we will complete any forms required by your dental insurance company. Your signature, on the reverse side, authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay all our charges. Each fee is individual for the individual patient.