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 #: _____ 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 #: _____ 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 Amex

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 canner 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.					

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 10#	Social Security #	School/Employer
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.