Patient Name_____ Birthdate_____

Mailing Address_____City_____Zip_____

Home #: _____ Cell #: _____ Work #: _____ Okay to Call Work: Yes/No

Email Address: _____ Gender: Male / Female

Marital Status: Minor / Single / Married / Separated / Divorced

Person financially responsible for account: _____

Social Security # _____Birthdate_____ Phone **#:** _____

Mailing Address_____City_____Zip_____

Do we have permission to discuss treatment and finances with this person? _____

Dental Insurance Information

Policy Holder_____

SSN or ID #_____DOB_____

Insurance Co._____

Provider ph # _____

Secondary Dental Insurance Information

Policy Holder_____

SSN or ID #_____DOB_____

Insurance Co._____

Provider ph #_____

How did you hear about our office? _____

When was your last dental appointment? _____

Who should we notify in case of emergency? _____

Certification

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health.

Financial Agreement

I acknowledge that payment and co-payments are due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges for services or items provided to the patient or me. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. 90 days past due is grounds for collection action.

_____ _____

Signature Date