

Welcome to our Office!

Patient Information

Date _____

Name _____ Birthdate _____ Age _____

Home Phone () _____

Street Address _____

City _____ State _____ Zip _____

Social Security # _____

Sex: F M Single Married Widowed Divorced Minor

Patient's/Parent's Employer _____

Work Phone () _____ Cell Phone () _____

Whom May We Thank For Referring You? _____

Person To Contact of Emergency _____ Phone () _____

For your convenience, we offer the following methods of payment. How will you be paying today?

Credit card: Visa Mastercard Discover American Express

Personal Check Cash Financing

***You are responsible for your portion of payment in full at time of visit.**

Responsible Party

Person Responsible for this Account (if same as above, disregard) _____

Relation to Patient _____ Phone () _____

Dental Insurance Information

Name of Insured _____ Relation to Party _____

Birthdate _____ Social Security/Policy ID # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Do You Have Any Additional Dental Insurance? Yes No

Name of Insured _____ Relation to Party _____

Birthdate _____ Social Security/Policy ID # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

“Signature on file” Statement: I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not covered by this authorization. I hereby authorize release of any information relating to the insurance claim:

Employee/Patient Signature : _____