

NAME: _____ MARRIED ___ SINGLE ___ MINOR ___ MALE ___ FEMALE

MAILING ADDRESS: _____

STREET ADDRESS: _____

BIRTHDATE: _____ TELEPHONE: _____ /WORK: _____ /CELL: _____

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE: _____ SS# _____

DENTAL INS. CO.: _____ GROUP# _____ POLICYHOLDER _____

POLICYHOLDER EMPLOYER: _____ POLICYHOLDER SS# _____ BIRTHDATE _____

Has any member of your family ever been treated in our office? ___ YES ___ NO - IF YES, WHOM? _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

HUSBAND OR FATHER (if minor)

WIFE OR MOTHER (if minor)

LAST FIRST MI

LAST FIRST MI

ADDRESS

ADDRESS

TELEPHONE

TELEPHONE

BIRTHDATE SS#

BIRTHDATE SS#

EMPLOYER TELEPHONE

EMPLOYER TELEPHONE

PERSON TO CONTACT IN CASE OF EMERGENCY (Outside of Immediate Family/Household):

NAME: _____ TELEPHONE: _____ RELATIONSHIP: _____

PERSON RESPONSIBLE FOR ACCOUNT AND RELATIONSHIP: _____

METHOD OF PAYMENT:

CASH • CHECK • CREDIT CARD TYPE _____ NUMBER _____ EXP DATE _____

DOES RESPONSIBLE PARTY HAVE AN ACCOUNT ESTABLISHED WITH OUR OFFICE? _____

INSURANCE AUTHORIZATION

I hereby authorize this office to act as an agent in obtaining third party payment. Such payment, where applicable by law, will be paid directly to the Dental Office against my account. I understand that I am responsible for all costs of dental treatment regardless of insurance reimbursement or consideration. This authorization is valid until I notify the office otherwise.

NAME _____

DATE _____

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the release of my dental/medical histories and other information about my dental treatment in third party payors and/or other health professionals. I agree for images of my smile and/or existing pathology corrections to be used for patient education and/or promotional purposes. I understand there are/will be service fees (18% annually) applied to any unpaid balances after 59 days. In case of default of payment, I understand I will be responsible for all legal and/or collections costs incurred in effect with the collection of my account. I understand and agree that the office can obtain my credit report to aid in collection recovery and/or account management. The information on this page is correct to the best of my knowledge. This authorization is valid unless I notify the office in written form otherwise.

SIGNATURE OF RESPONSIBLE PARTY REQUIRED FOR ANY TREATMENT

NAME _____ DATE _____

