

WELCOME TO THE OFFICE

Patient personal information

Name _____ Birthdate _____
Social Security Number _____ Nickname _____
 Male Female single married divorced separated widowed
Address _____
City, State, Zip _____ Home phone _____
Employer _____ Occupation _____ Work phone _____
Other phone _____ (cellular, pager) e-mail _____
We do not sell, trade or otherwise give any information about our patients to any outside vendors.
Someone not living with you to notify in case of emergency _____ Phone _____

Who referred you so we may thank them? _____

Responsible party (Who will pay for this account: must be yourself, spouse or legal guardian)

Name _____ Birthdate _____
Relationship to patient _____ Social security number _____
Address _____
City, State, Zip _____
Employer _____ Occupation _____ Work phone _____

Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured's birthdate _____	Insured's birthdate _____
Soc. Sec. # _____	Soc. Sec. # _____
Insurance Company _____	Insurance Company _____
Membership # _____	Membership # _____
Group # _____	Group # _____
Effective date of insurance _____	Effective date of insurance _____

Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning patient's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning patient's health care, advice and treatment to another dentist that this dentist may refer me to.

I authorize the usage of any x-rays, photos, models, molds of my mouth to be used for patient education.

I authorize and request the insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that the dental insurance carrier may pay less than the actual fees for services.

I agree to be responsible for all services rendered on the patient's behalf. I also agree to be responsible for any financial charges or legal fees incurred in collecting any amounts owed to the dentist. Late fees and charges of 1.5% per month are charged for payments made 60 or more days after treatment is started.

I attest to the accuracy of the information on this page.

Signature of patient or parent/legal guardian _____ relationship to patient _____ date _____