

TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

Patient Information

SECTION 1

Date: _____

Name: _____ Married Single Minor Male Female
Last First M

Birth Date: ____/____/____ SS# ____-____-____ Drivers License Number: _____

Address: _____
Street Apt # City State Zip

E-Mail Address _____ Phone – Home: _____

Phone – Work: _____ Ext. _____ Time to Call: _____ Cell: _____

Place of Employment _____ Occupation/Position _____

If Full time Student, School Name: _____ Grade _____

Medical Insurance Company: _____ ID# _____ Group # _____

Dental Insurance Company: _____ ID# _____ Group # _____

Has any member of your family been treated in our office? Yes No Local # _____

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

Insured Information

Father **Husband**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Mother **Wife**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Emergency Information

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Responsible Party

Responsible party currently is a patient of record at this office Yes No

Method of Payment:
 Patients will be expected to pay for services when treatment is rendered.
 Visa/MasterCard are accepted.
 I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided **to you, our patient, and not to an insurance company**. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient**.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. 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. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me or parts of my body, for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: _____ Date: _____

- Adult Patient Father Husband Mother Wife Guardian

