

We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? \_\_\_\_\_

### Patient Information

Patient's Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Email Address \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ If patient is a minor, give parent's/guardian's name \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

### Responsible Party Information

Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Marital Status \_\_\_\_\_  
Residence Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mailing address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### Secondary Insurance Information

If you have dual coverage, please fill out the following:

Spouse's Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### Payment Responsibility

*For our patients without dental insurance.....*I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

*For our patients with dental insurance.....*I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of all dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office. If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all collection costs.

I understand that it is my responsibility to advise your office of any changes in the information on this form.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_