PATIENT INFORMATION - Adult

DATE _____

NAME _____ ❒ MARRIED ❒ SINGLE ❒ MALE ❒ FEMALE
LAST FIRST M

SS# _____ BIRTH DATE _____
MONTH DAY YEAR

ADDRESS _____
STREET APT. # CITY STATE ZIP

Telephone _____ / _____ / _____ / _____
HOME WORK CELL FAX

PLACE OF EMPLOYMENT _____

Spouse Name _____ Telephone _____ / _____
LAST FIRST M WORK CELL

Spouse Place of Employment _____ SS# _____

DENTAL INSURANCE INFORMATION

*** DO NOT LIST MEDICAL INSURANCE**

PRIMARY INSURED

Subscriber _____
LAST FIRST M

Relationship ❒ SELF ❒ SPOUSE
❒ OTHER _____

SUBSCRIBER ID# GROUP #

NAME OF GROUP

NAME OF INSURANCE COMPANY

CLAIMS ADDRESS & TELEPHONE

SECONDARY INSURED

Subscriber _____
LAST FIRST M

Relationship ❒ SELF ❒ SPOUSE
❒ OTHER _____

SUBSCRIBER ID# GROUP #

NAME OF GROUP

NAME OF INSURANCE COMPANY

CLAIMS ADDRESS & TELEPHONE

ALTERNATE CONTACT

OUTSIDE OF FAMILY HOUSEHOLD

Name _____
Relationship _____
Address _____
City/State/ZIP _____
Telephone # (Hm) (Wk)
(Cell)

AUTHORIZATION

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, photographic 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 payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

*** INSURED PATIENTS PAY DEDUCTIBLE AND CO-PAYS**

❒ Payment in full at each appointment (cash or check)

❒ Payment in full at each appointment (Visa, MC, Discover)

Card # _____ Exp. Date _____

I, _____ authorize automatic charge
SIGNATURE

to the above listed account of any dental expenses due.

❒ Office Payment Plan
You must be approved prior to dental care. Please ask receptionist for application.

SERVICE CHARGE

Any account balance over 90 days is subject to an annual percentage rate of 12%.