

WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last name First name Initial

Birthdate _____ Sex _____ Age _____ Soc. Sec. # _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell phone _____

E-Mail _____ Drivers License # _____

How did you hear about our practice? _____

Employer _____ Occupation _____ How long there? _____ May we call? _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____

Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____

Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school/college: _____ City & State _____ Full time or part time? _____

Primary Insurance:

Name of Insured _____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Social Security # _____ Subscriber ID # _____

Group, Contract or Local or union # _____

Additional Insurance:

Name of Insured _____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Social Security # _____ Subscriber ID # _____

Group, Contract or Local or union # _____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa MasterCard Discover Amex
Account# _____ Expiration date _____ Name on card _____

Credit Card Debit Card ATM Voided check attached.

In Case of Emergency:

Name and City of primary care physician _____

Someone we may contact, not living with you: _____ Phone #'s (home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Patient or Responsible Party