Please complete the following confidential information.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can serve you.

1- Personal information

A. PATIENT:

Name _____

Today's Date _____ Birthdate ___ / ___ / ___

Preferred Nickname? _____ Age _____

Address _____

_____ Zip Code _____

H. Phone _____ Cell _____

Other Phone Numbers _____

E-mail Address _____

Married ___ Single ____ Divorced ____ Widowed___

Social Security No _____

Driver License No _____

Occupation _____

Employer _____

Business Address _____

Business Phone (____) ____ - _____ Ext. _____

If minor, please give name of parent or legal guardian:

_____

Referred by _____

Person to contact in case of emergency _____

_____ Phone _____

B. SPOUSE:

Name _____

Social Security No _____

Driver License No _____

Occupation _____

Employer _____

Business Address _____

Business Phone (____) ____ - _____ Ext. _____

2- Account information

A. RESPONSIBLE PARTY: (if different from patient)

Name _____

Relationship to Patient _____

Date of Birth _____

Address _____

_____ Zip Code _____

Phone Number (____) ____ - _____ Ext. _____

Business Address _____

Social Security No _____

Driver License No _____

B. PRIMARY DENTAL INSURANCE:

Name of Insured _____

Date of Birth of Insured _____

SSN or Ins. ID _____

Relationship to Patient _____

Employer _____

Insurance Co _____

C. SECONDARY DENTAL INSURANCE:

Name of Insured _____

Date of Birth of Insured _____

SSN or Ins. ID _____

Relationship to Patient _____

Employer _____

Insurance Co _____

3- Terms and Conditions:

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any services performed without prior financial arrangement, must be paid for in cash at the time of service.

I understand that dental services rendered are charged directly to me and that I am personally responsible for payment for all dental services performed.

If I carry insurance, I understand that this office will help prepare forms to assist in making collections from insurance companies and will credit such collections to my account.

I authorize the dental office to release any information, including the diagnosis and records of any dental treatment rendered, to third party payers or other health care practitioners.

I authorize my insurance company to pay directly to the dental office for any exam or treatment rendered to my dependents or me from benefits accruing to me under my dental policy.

I understand that my dental insurance carrier may pay less than the actual estimate given to me for the services rendered. My benefits are based purely on a contract between my insurance company and myself. I agree to be responsible for full payment on all services rendered to my dependents or me.

I understand there is a 1.5% monthly finance charge (18% annually) for any balance 60 days overdue.

I authorize this dental office to call or text me on my home, work or cell phone to discuss relevant treatment, account and insurance information. I can withdraw my consent anytime.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the above conditions and agree to their content.

Signature _____

Date _____