Patient Information

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Gender: _____ Married _____Single_____ Minor_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work):_____(Cell): _____

E-mail Address: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Referring Dentist:_____

Insurance Information

Primary

Insurance Plan Name: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Insurance Plan Name: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

***Method of Payment/ Financial Policy*:** Payment in full is due at the time of services. We accept cash, check, Visa, MasterCard, and Interest free financing is available through Care Credit. If you have dental insurance we will process the forms for you, we request you pay your estimated portion when services are rendered. All appointments are confirmed by phone or e-mail; we require confirmation back from you. Our office policy is to charge 25% of the appointment fee, for broken appointments without a 48 hour notice. In the event of repeat cancellations, we reserve the right to request a deposit prior to rescheduling.

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

Please Initial: _____

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 cost of dental treatment. The information on this page is correct and I grant the right to the dentist to release my dental/ medical history and other information about my dental treatment to third party including the insurance company or other healthcare professionals.

I grant my permission to you or your assignee, contact me to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party