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Patient Information (CONFIDENTIAL)

Today's Date ____________

Name ____________ *Birthdate* ____________

Address ____________ *City* ____________ *State* ______ *Zip* ______

Home Phone ____________ *Cell Phone* ____________ *Soc. Sec. #* ____________

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Patient's or Parent's Employer ____________ *Work Phone* ____________

Business Address ____________ *City* ____________ *State* ______ *Zip* ______

Spouse or Parent's Name ____________ *Employer* ____________ *Work Phone* ____________

If Patient is a Student, Name of School/College ____________ *City* ____________ *State* ______

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ *Phone* ____________

Responsible Party

Name of Person Financially Responsible for this Account ____________ *Relationship to Patient* ____________

Address ____________ *Home Phone* ____________

Employer ____________ *Work Phone* ____________

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

Primary Dental Insurance Information

Name of Insured ____________ *Relationship to Patient* ____________

Birthdate ____________ *Social Security #* ____________ *Date Employed* ____________

Name of Employer ____________ *Work Phone* ____________

Address of Employer ____________ *City* ____________ *State* ______ *Zip* ______

Insurance Company ____________ *Group #* ____________ *Union or Local #* ____________

Ins. Co. Address ____________ *City* ____________ *State* ______ *Zip* ______

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ *Yes* ☐ *No* IF YES, COMPLETE THE FOLLOWING:

Secondary Dental Insurance Information

Name of Insured ____________ *Relationship to Patient* ____________

Birthdate ____________ *Social Security #* ____________ *Date Employed* ____________

Name of Employer ____________ *Work Phone* ____________

Address of Employer ____________ *City* ____________ *State* ______ *Zip* ______

Insurance Company ____________ *Group #* ____________ *Union or Local #* ____________

Ins. Co. Address ____________ *City* ____________ *State* ______ *Zip* ______

I understand that I am financially responsible for payment in full for dental services provided in the office to myself (or my dependent), regardless of insurance. I understand that payment is due at the time service is rendered and that a finance charge of 1 1/2% per month (18% APR) will be assessed on any balance remaining after 90 days from the date of service. In the event of default, I/we promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorneys fees.

Signature ____________ *Date* ____________