PATIENT INFORMATION

Print Form Submit by Email

PATIENT INFORMATION

☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

NAME: _____

ADDRESS: _____
Street Apt# City State Zip

BIRTHDATE: _____ SOC SEC#: _____ HOME PHONE#: _____
Mo/Day/Yr

E-MAIL ADDRESS: _____ CELL#: _____

EMPLOYER: _____ PHONE#: _____

ADDRESS: _____
Street City State Zip

ACCOUNT INFORMATION (Person Responsible for Billing)

NAME: _____

ADDRESS: _____
Street Apt# City State Zip

BIRTHDATE: _____ SOC SEC#: _____ HOME PHONE#: _____
Mo/Day/Yr

EMPLOYER: _____ PHONE#: _____

ADDRESS: _____
Street City State Zip

Who may we thank for referring you to our office? _____

Do you have Dental Insurance? ☐ Yes ☐ No

ABOUT FINANCIAL ARRANGEMENTS

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa or Discover.

Balances older than 60 days will be subject to an **interest charge of 1 1/2% per month.** Charges may be incurred for broken appointments and appointments cancelled without 24 hours advanced notice.

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 and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

IN CASE OF AN EMERGENCY THE PERSON TO CALL (Not Living with You)

NAME: _____ PHONE#: _____

ADDRESS: _____
Street Apt# City State Zip

SIGNATURE OF RESPONSIBLE PARTY

X _____ Date _____

☐ Adult ☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

OFFICE USE ONLY

Account #	Doctor	Update	Add On	New	Risk	Initials

UPDATE
