# PLEASE COMPLETE THE FOLLOWING

**Confidential Information**

**Personal Information**

Date:_____

Name_____

Mailing Address_____

City_____State_____Zip Code_____

Home Phone #_____

Birth Date_____

SSN _____

Married_____ Single_____ Divorced_____ Widowed_____

Spouse's or Guardian's Name_____

Person to contact for emergency_____

Phone #_____

Who may we thank for referring you? _____

Is another member of your family or relative a patient at our office? _____

**Account Information**

Person responsible for account:

_____

Occupation_____

Employer_____

Business Address_____

City_____

Business Phone_____

**Your Spouse or Guardian**

Name_____

Occupation_____

Employer_____

Business Address_____

_____

Business Phone_____

**Payment is due at time of service. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for all fees incurred** REGARDLESS OF MY INSURANCE**. I hereby assign payment of dental benefits be made directly to River Rock Oral Surgery for services rendered in this office. There is a $25.00 fee for returned checks. If my account becomes delinquent and sent to a collection service I am responsible for all costs incurred.**

**Signature**_____ **Date**_____

## PRIMARY DENTAL INSURANCE

Insurance Carrier_____

Group #_____

Employer_____

Employee_____

Employee SSN_____Date of Birth_____

## SECONDARY DENTAL INSURANCE

Insurance Carrier_____

Group #_____

Employer_____

Employee _____

Employee SSN_____Date of Birth_____